Member HIPAA Notification

MODOT/MSHP Medical and Life Insurance Plan

In 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA). This legislation affects many aspects of group health insurance plans, mandating measures that must be taken to protect the privacy of members. Compliance with the privacy rules of HIPAA must be established by April 14, 2003.

You have the right to see and obtain copies of your health care records, and to request amendments to those records. You also have the right to issue a complaint about suspected HIPAA violations by our Plan. In order to do any of these things you may contact the designated privacy officer. The privacy officer for our Plan is Jeff Padgett, Manager of Employee Benefits, MoDOT, P.O. Box 270, Jefferson City, MO 65102.

You have the right to grant consent authorizing another person to access your protected health information (PHI). This will allow your designated representative to discuss your PHI with parties that are involved with your health care. You may have to complete a number of these authorizations depending upon the number of entities involved in the delivery of and payment for your health care. Except in the case of a minor child, PHI can only be shared with the patient. PHI cannot be shared with spouses, children or other parties unless notarized authorization(s) have been completed and filed with the entities involved.

THE MISSOURI DEPARTMENT OF TRANSPORTATION
AND
MISSOURI STATE HIGHWAY PATROL
MEDICAL AND LIFE INSURANCE PLAN

Effective January 1, 2003, the Missouri Highway and Transportation Commission acting by and through the Board of Trustees of the Missouri Department of Transportation (MoDOT) and the Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan (the "Board of Trustees"), hereby adopts the amended and restated Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan, (herein after called Plan). This amended and restated Plan is the basis for calculating benefits for medical care services and supplies received.

The purpose of the Plan is to provide hospital, surgical, medical, and life insurance coverage for certain individuals and dependents who are eligible in accordance with the terms and conditions of the Plan.

NOTE: Pre-certification is required as stated in Article IX, Sections 9.01, 9.02 and 9.03. You, your physician, or facility must call the utilization review organization for pre-approval. Ultimately, it is the subscriber's responsibility to assure pre-certification has been obtained. Failure to obtain Pre-Admission Certification will result in a 20 percent reduction (not to exceed $1,000) in the total allowed amount before plan benefits are determined. Costs incurred for admissions or services that are not medically necessary are not allowed amounts and 100 percent of such costs will be deducted before plan benefits are determined.

Visit MoDOT's website @ www.modot.org, under "Publications", or the MSHP website @ www.mshp.state.mo.us under "Medical Insurance" for the most current plan document.

First Printing - January 1, 1991
Second Printing - January 1, 1997
Third Printing – May 1, 1999
Fourth Printing – January 1, 2001
Fifth Printing – January 1, 2003

IF YOU NEED INFORMATION

To ensure that you receive accurate information regarding your medical and life insurance benefits you should direct your questions **ONLY** to the sources listed below. **NO ONE ELSE** is authorized to give you information.

For information about your medical benefits or claims, call the toll-free number of the claims administrator listed on the back of your medical insurance identification card or prescription drug card.

For information regarding enrollment in the medical and life insurance plans, contact the insurance representative at your district, division or troop assignment as follows:

MoDOT Districts: Contact your district insurance representative.

District 1	-	St. Joseph	(816) 387-2405
District 2	-	Macon	(660) 385-8252
District 3	-	Hannibal	(573) 248-2456
District 4	-	Kansas City	(816) 622-6305
District 5	-	Jefferson City	(573) 526-5139
District 6	-	Chesterfield	(314) 340-4216
District 7	-	Joplin	(417) 629-3309
District 8	-	Springfield	(417) 895-7614
District 9	-	Willow Springs	(417) 469-6222
District 10	-	Sikeston	(573) 472-5368

MoDOT General Headquarters: Contact your office manager or designated insurance representative in your functional unit.

General Headquarters - Jefferson City ..... (573) 751-2551

MSHP Troops: Contact your troop secretary.

Troop A	-	Lee's Summit	(816) 622-0800, ext. 242
Troop B	-	Macon	(660) 385-2132
Troop C	-	Kirkwood	(314) 340-4059
Troop D	-	Springfield	(417) 895-6868, ext. 229
Troop E	-	Poplar Bluff	(573) 840-9500
Troop F	-	Jefferson City	(573) 526-6329, ext. 28
Troop G	-	Willow Springs	(417) 469-3121
Troop H	-	St. Joseph	(816) 387-2345, ext. 37
Troop I	-	Rolla	(573) 368-2345

MSHP Contact – Contact the insurance representative:

GHQ – Jefferson City ..... (573) 526-6136

MoDOT Contacts -

Senior Benefits Specialist	(573) 751-5704
Senior Benefits Specialist	(573) 751-2861
Senior Benefits Specialist	(573) 522-8121
Toll-free	1-877-863-9406

The plan document is also available on the MoDOT website: www.modot.org, under "Publications," and the MSHP website: www.mshp.state.mo.us under "Medical Insurance."

MISSOURI DEPARTMENT OF TRANSPORTATION

NOTE TO INSURANCE REPRESENTATIVES

For quick reference, we are providing you with selected telephone numbers, websites and addresses as follow:

Westport Benefits

Benefits or Claim Information 1-888-306-6681
website: www.westportbenefits.net

Mailing Address: Westport Benefits
PO Box 66743
St. Louis, MO 63166-6743

Health Link/Freedom Network

Utilization Management Program (Pre-certification) 1-888-724-9395
Provider Locator website: www.HealthLink.com

Mailing Address: HealthLink/Freedom Network
P.O. Box 411160
St. Louis, MO 63141-1640

Eckerd Health Services (TDI)

Retail Pharmacy Questions 1-888-414-3141
website: www.EHS.com

Mailing Address: Eckerd Health Services
620 Epsilon Drive
Pittsburgh, PA 15238

Express Pharmacy Services

Mail Order Questions..... 1-888-414-3141

Mailing Address: Express Pharmacy Services
P.O. Box 270
Pittsburgh, PA 15230-9949

THE MISSOURI DEPARTMENT OF TRANSPORTATION
AND MISSOURI STATE HIGHWAY PATROL
MEDICAL AND LIFE INSURANCE PLAN

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MEDICAL PLAN

ARTICLE I

DEFINITIONS

1.01 Allowed Amount means the charge for covered services provided to a participant for which benefits may be payable, as determined reasonable by the Plan. In the case of a physician or other professional provider, the allowed amount is the usual, customary and reasonable charge or the charge determined by other specified methods.

1.02 Ambulatory Care Facility means a provider with an organized staff of physicians that:

(a) has permanent facilities and equipment for the primary purpose of performing surgical and/or medical procedures on an outpatient basis;

(b) provides continuous nursing services and treatment by physicians whenever the participant is in the facility;

(c) does not provide inpatient accommodations,

(d) is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician; and

(e) is licensed as an ambulatory care facility.

1.03 Benefit means the Plan's payment or reimbursement for covered services as outlined in the Schedule of Benefits set forth in Article IV.

1.04 Benefit Acceleration Point ("BAP") means the point at which the plan increases its co-insurance to 100 percent of the allowed amount for covered services. Expenses counted toward the BAP do not include:

(a) deductible amount;

(b) cost of any service or supply that is not a covered service;

(c) charges in excess of the allowed amount; or

(d) amounts resulting from reductions in benefits due to the participant's (or provider's) failure to comply with the cost containment provisions

When the BAP is reached, the level of benefits is increased, as specified.

1.05 Board of Trustees means the body established by the Missouri Highways and Transportation Commission to provide for the general administration of the Plan. The Board consists of eight members as follows:

(a) four MoDOT employees appointed by its Director;

(b) two MSHP employees appointed by its Superintendent;

(c) one retired MoDOT employee appointed by its Director; and

(d) one retired MSHP employee appointed by its Superintendent.

All appointees must be approved by the Missouri Highways and Transportation Commission prior to performing any Board duties.

1.06 Claims Administrator means the person or entity duly authorized by the Board of Trustees, as contracted from time to time, to process claims.

1.07 Clinical Psychologist means a person who provides clinical psychological services in connection with the diagnosis or treatment of mental, psychoneurotic or personality disorders, and who is duly licensed as a psychologist.

1.08 Code means the Internal Revenue Code of 1986, as amended.

1.09 Common-Law Spouse means a spouse in a common-law marriage, which occurs prior to the parties residing in Missouri, in a state that recognizes common-law marriage. The Plan will permit the common-law spouse of the member to be a dependent under Section 1.16(a) as a lawful spouse. Proof of common-law marriage will be required by the Board.

1.10 Co-insurance means the shared portion of payment between the Plan and the member where each pays a percentage of medical expenses (reference Appendix A, Page 26).

1.11 Co-payment means a fixed fee required by the Plan to be paid by the patient at the time of each participating provider (PPO/HMO) office visit or emergency room visit.

1.12 Coverage Date means the date on which participation begins under the Plan provided all requirements and conditions for participation have been satisfied and performed.

1.13 Covered Service means a service or supply specified in Article VI for which benefits will be furnished, subject to the deductible and other requirements for payment by the plan, when rendered by a provider (reference Section 1.44). A charge for a covered service will be considered to have been incurred on the date the service or supply was provided to the participant. Eligibility for payment of benefits, including obstetrical benefits without limitations, will be determined on the date the service is rendered.

1.14 Custodial Care means care provided primarily for the convenience of the participant or his family, maintenance of the participant, or which is designed essentially to assist the participant in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to:

(a) help in walking, bathing, dressing, feeding;

(b) preparation of special diets;

(c) supervision over self-administration of medications not requiring constant attention of trained medical personnel; or

(d) acting as a companion or sitter.

Unless a participant is receiving medical, surgical, or psychiatric treatment that is intended or designed to permit him to live outside a hospital or skilled nursing facility, the care being provided will be deemed custodial care.

1.15 Deductible means a specified amount of allowed amounts for covered services per calendar year, expressed in dollars that must be incurred and paid by a participant before the plan will assume any benefit liability.

1.16 Dependent, as of actual date of board approval means:

(a) subscriber's lawful spouse; lawful surviving spouse; or common-law spouse (reference Section 1.09);

(b) subscriber's unmarried natural born or unmarried legally adopted child up to age 19, or 23, if a full time student, excluding any child who is a member of the armed forces of any country;

(c) subscriber's unmarried stepchildren up to age 19, or 23 if a full time student, if such individual:

(i) resides with the subscriber in his household, except if the individual is a full-time student (reference def. 1.26); and

(ii) the subscriber contributes more than 50 percent toward the support of such individual. Excluded is any stepchild who is a member of the armed forces of any country;

(d) subscriber's unmarried grandchild up to age 19, or age 23 if a full time student, if such grandchild:

(i) resides with the subscriber in his household; except if the grandchild is a full-time student, (reference Section 1.26); and

(ii) the subscriber contributes more than 50 percent toward the support of such grandchild; or

(e) subscriber's niece or nephew for whom he is legal guardian, up to age 19, or age 23 if full-time student, if:

(i) such individual resides in his household; except if the individual is a full-time student, (reference Section 1.26);

(ii) the subscriber contributes more than 50 percent toward the support of such individual; and

(iii) Proof of legal guardianship is provided; or

(f) dependents of a subscriber enrolled in the Plan and continue to meet the eligibility requirements stated above who are mentally retarded and/or physically disabled, and incapable of self-support regardless of age, during the continuance of such disability and incapacity. Periodic proof that an individual qualifies under this subsection may be required by the Board.

1.17 Diagnostic Admission means an inpatient admission that occurs even though the participant's condition does not require the constant availability of medical supervision or skilled nursing care and could reasonably be diagnosed on an outpatient basis. The primary purpose of such an admission is to arrive at a diagnosis through the use of x-ray and laboratory tests, consultations, and evaluation, whether or not treatment is provided during the admission. The Board may rely on the hospital's medical records, among other evidence, to assist in determining the primary purpose of the admission.

1.18 Diagnostic Service means a test or procedure that is rendered because of specific symptoms and that is directed toward the determination of a definite condition or disease and its subsequent treatment. A diagnostic service must be ordered by a physician. Diagnostic services may include:

(a) x-ray and other radiology services. Magnetic Resonance Imaging (MRI) is limited to examinations of the brain, spinal cord/spine, temporomandibular joint (TMJ), knee and shoulder;

(b) laboratory and pathology services; or

(c) cardiographic, encephalographic, and radioisotope tests.

1.19 Election Period means the 60-day period beginning with the date an individual becomes an employee. However, this period will be extended for each day during this period the employee was incapacitated and unable to apply for coverage.

1.20 Emergency Care means:

(a) the treatment of traumatic bodily injuries resulting from an accident; or

(b) the treatment of a medical condition manifesting itself by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

(i) permanently placing the participant's health in jeopardy;

(ii) causing other serious medical consequences to the participant;

(iii) causing serious impairment to the participant's bodily functions; or

(iv) causing serious and permanent dysfunction of any bodily organ or part of the participant.

1.21 Employee means an individual who is a member of the Highway and Transportation Employees' and Highway Patrol Retirement System, as defined by state law.

1.22 Employer means the Missouri Department of Transportation (MoDOT) or the Missouri State Highway Patrol (MSHP).

1.23 Employer or State Contribution means the contribution authorized by the State of Missouri and paid out of operating funds of the employer to fund the benefits provided under the Plan as defined in Section 13.02.

1.24 Experimental/Investigative means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted by the claims administrator as standard medical treatment of the condition being treated, or any of such items requiring federal or other government agency approval not granted at the time services were rendered.

1.25 Freestanding Renal Dialysis Facility means a provider other than a hospital that is primarily engaged in providing renal dialysis treatment, maintenance or training to participants on an outpatient or home care basis.

1.26 Full-Time Student means a dependent, under 23 years of age, who enrolls and attends the number of hours or courses the school considers to be full-time attendance during some part of each of five calendar months during the calendar year. This allows them to stay in the Plan as a dependent for the remainder of that year. School means high school or accredited colleges, universities, technical, trade and mechanical schools.

If a dependent is at least 19 and not enrolled in the spring semester of that calendar year, they will be required to enroll in Continuation of Coverage (see Article XI) as a "COBRA member" until such time as they become full-time students and qualify as a dependent. The age of 23, even if a full-time student, requires them to enroll in COBRA or terminate coverage. The plan administrator will verify full-time student status at least annually.

1.27 HMO means a Health Maintenance Organization, a managed care plan where services must be received from HMO network providers in order to have your claim paid at the HMO level of benefits. Treatment received outside the HMO network may not be covered or may be covered at a reduced level. For purposes of the Plan, this is applicable to the Open Access III plan.

1.28 Hospital means:

(a) an institution that is operated pursuant to law and is primarily engaged in providing for compensation, on an inpatient basis, for the medical care and treatment of sick and injured persons through medical, diagnostic and surgical facilities, all of which facilities must be provided on its premises, under the supervision of a staff of one or more physicians and with 24 hour-a-day nursing service by a registered nurse (R.N.) on duty; or

(b) an institution accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

In no event will the term "hospital" include a convalescent nursing home or any institution or part thereof that is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged.

1.29 Inpatient means a participant who receives treatment as a registered bed patient in a hospital and for whom a room and board charge is made.

1.30 Intensive Care Unit means a section, ward or wing within a hospital that meets all of the following requirements:

(a) is solely for the treatment of patients who are in critical condition;

(b) provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;

(c) provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;

(d) contains at least two beds for the accommodation of critically ill patients; and

(e) provides at least one registered nurse (R.N.) who continuously and constantly attends the patients confined in such area on a 24-hour-a-day basis.

1.31 Long-Term Disability Recipient means a subscriber who has been determined by the Board of Trustees of the Missouri Highway and Transportation Employees' and Missouri Highway Patrol Retirement System to be eligible to receive long-term disability benefits.

1.32 Medically Necessary means, in connection with services or supplies furnished by a provider, required in the identification or treatment of a participant's condition as determined to be:

(a) consistent with the symptom or diagnosis and treatment of the participant's condition, disease, ailment, or injury;

(b) appropriate with regard to standards of good medical practice;

(c) not solely for the convenience of a participant or provider; and

(d) the most appropriate supply or level of service that can be safely provided to the participant.

When applied to inpatient care, it means the participant's medical symptoms or condition requires that the services cannot be safely provided to the participant as an outpatient.

1.33 Medicare Member means an individual who is eligible for coverage under Title XVIII of the Social Security Act of 1965, as amended (Medicare). Medicare member does not include an active employee or their dependent, (except when Medicare eligibility is for reasons of a kidney transplant or renal dialysis).

1.34 Mental Health means a disturbance of the mental processes of the human mind manifested in a psychotic or neurotic condition or reaction including but not limited to manic-depression, autism, and other such conditions. Alcoholism, drug addiction and overdose, for the purposes of the Plan and in determining any benefit due hereunder, are included.

1.35 Non-Participating Provider means no arrangement has been made with a health care service provider for cost containment. If the cost of a covered service exceeds the allowed amount, the subscriber will be responsible for such excess.

1.36 Open Access III means a three tier benefit plan, which offers HMO, PPO and out-of-network level of benefits in accordance with the Plan.

1.37 Out-of-Network means no arrangement has been made with a health care service provider for cost containment. If the cost of a covered service exceeds the allowed amount, the subscriber will be responsible for such excess.

1.38 Outpatient means a participant who receives services while not an inpatient.

1.39 Participant means an individual enrolled in the plan, including an employee, retiree, vested member, work-related disability recipient, long-term disability recipient, surviving spouse, any of their dependents, or such persons who are entitled to continued coverage under other provisions of the plan, but excluding a Medicare member.

1.40 Physician means a licensed practitioner of the healing arts, acting within the scope of his license, limited to a doctor of medicine, doctor of osteopathy, podiatrist, doctor of dental medicine, and doctor of dental surgery.

1.41 Plan means the amended and restated Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan, herein after called Plan.

1.42 Plan Sponsor means the Missouri Highways and Transportation Commission.

1.43 Preferred Provider Organization (PPO) means an arrangement has been made with providers where reimbursements for health care services are furnished at discounted rates. Under this arrangement the subscriber is not responsible for charges above the allowed amount determination. The provider will file all claims for you and should not ask for payment at the time of service.

1.44 Provider means a facility, person, or entity, including a hospital or physician that possesses a valid license to render covered services. Providers other than a hospital or physician include:

(a) Ambulatory Care Facility
(b) Certified Nurse Practitioner
(c) Chiropractor
(d) Clinical Psychologist
(e) Clinical Social Worker
(f) Community or Hospital Home Healthcare Agency
(g) Doctor of Optometry
(h) Doctor of Surgical Chiropody
(i) Freestanding Renal Dialysis Facility
(j) Licensed Massage Therapist under direction of a physician (claim must be submitted by and payable to a physician)
(k) Occupational Therapist
(l) Physical Therapist
(m) Physiotherapist
(n) Private Duty Nurse (registered nurse (RN) or licensed practical nurse (LPN)
(o) Professional Counselor

(p) Psychiatric Facility
(q) Registered Pharmacist
(r) Respiratory Therapist
(s) Skilled Nursing Facility
(t) Speech Therapist

1.45 Psychiatric Facility means a provider that for compensation from its patients is primarily engaged in providing diagnostic and therapeutic services for the treatment of nervous or mental disorders.

1.46 Retiree means an:

(a) individual who has retired from MoDOT or MSHP under the provisions of Sections 104.010 through 104.270, RSMo. and 104.1072 RSMo., provided such retired individual was, on the day preceding the effective date of the Plan, covered under the Plan that provided medical care benefits exclusively for employees who are members of the Highway and Transportation Employees' and Highway Patrol Retirement System; or

(b) Former employee of MoDOT or MSHP retiring after the effective date of the Plan under the provisions Sections 104.010 through 104.270, RSMo. and 104.1072 RSMo, provided such former employee was in the Plan from the date of last employment until the date of retirement (vested member).

Retiree, for the purpose of the Plan, will include any participant receiving normal or work-related disability retirement benefits.

1.47 Skilled Nursing Facility means a provider that is primarily engaged in providing 24-hour-a-day skilled nursing and related services at the facility to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of physicians and eligibility for payment is based on care rendered in compliance with the Medicare-established guidelines. A skilled nursing facility is not, other than incidentally, a place that provides:

(a) minimal care, custodial care, ambulatory care, or part-time care services; or

(b) care or treatment of a nervous or mental disorder, alcoholism, drug abuse, or pulmonary tuberculosis.

1.48 Special Enrollment Period means enrollment for the following reasons:

(a) life events including marriage, birth, adoption;

(b) loss of eligibility under other insurance coverage;

(c) loss of employer contribution to spouse's plan;

(d) enrolling dependents under court order;

(e) COBRA coverage ends with previous employer; or

(f) loss of Medicaid coverage.

The special enrollment period does not apply to retiree's, vested member's, long-term disability recipient's or surviving lawful spouses' (or their dependent's) coverage or a participant under Article XI, if their coverage under the Plan terminates for any reason, except if their coverage terminates due to active military duty. Upon return from military duty, the participant can be reinstated in the Plan (reference Sections 2.09 and 3.02(d)).

1.49 State means the state of Missouri.

1.50 Subscriber means the principal eligible individual from whom coverage under the Plan for dependents emanates.

1.51 Subscriber Contribution means the periodic contribution required from the subscriber for coverage under the plan.

1.52 Therapy Service means services or supplies used to promote the recovery of the participant. Therapy services are limited to the following:

(a) Radiation Therapy;
The treatment of disease by X-ray, radium, or radioactive isotopes;

(b) Chemotherapy;
The treatment of malignant disease by chemical or biological antineoplastic agents;

(c) Renal Dialysis Treatment;
The treatment of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine;

(d) Physical Therapy;
The treatment by physical means includes:

(i) hydrotherapy, or similar modalities;

(ii) bio-mechanical and neurophysiological principles;

(iii) devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part;

(iv) massage therapy conducted by a physician (excluding chiropractors), or conducted by a licensed massage therapist under the direction of a physician and the bill is submitted by and payable to the physician; or

(v) cardiac rehabilitation services for a participant who has suffered a heart attack, or undergone coronary bypass surgery, within the 12 months before receiving such cardiac rehabilitation services.

(e) Respiratory Therapy;
Introduction of dry or moist gases into the lungs for treatment purposes;

(f) Occupational Therapy;
Treatment of a physically disabled participant by means of constructive activities designed and adapted to promote the restoration of the participant's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the participant's particular occupational role;

(g) Speech Therapy;
Treatment by a qualified speech therapist for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes. If loss or impairment is due to a congenital or developmental anomaly, surgery to correct such anomaly must be performed prior to any therapy.

1.53 Usual, Customary and Reasonable (allowed amount), for purposes of determining the amount of provider fees recognized by the Plan, have the following meanings:

(a) Usual - the fee a physician or other provider most frequently charges the majority of his patients for the same or similar services;

(b) Customary - the range of fees charged in a geographic area by physicians or other providers of comparable skills and qualifications for the same performance of a similar service. The customary maximum is the usual charge by 90 percent of the doctors or other providers for 90 percent of the medical services reported; and

(c) Reasonable - the flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

In practice, other billed charges are recognized, up to the physician's or provider's usual charge if it is less than the customary charge. Any extenuating circumstances are considered under the flexibility allowed by reasonable. If the physician or other provider substantiates the greater charge to the satisfaction of the claims administrator, it will be recognized.

1.54 Utilization Review Organization means a company, or division within a company, that employs qualified health care professionals and specializes in the business of evaluating medical records for prospective or retrospective determination of appropriateness of treatment.

1.55 Vested Member means an individual who, between April 1, 1984 and August 13, 1988, or after June 14, 1989, terminated employment with MoDOT or MSHP while participating in the Plan and after becoming vested in his right to a benefit at retirement from the Highway and Transportation Employees' and Highway Patrol Retirement System.

ARTICLE II

ELIGIBILITY

2.01 Employee Eligibility

Any new employee will be eligible to become a participant effective on the first day of the next calendar month following date of employment. However, if the new employee was enrolled in the Plan as a dependent immediately prior to the date of employment, the creditable service requirement is waived. Eligibility is subject to submission of proper application and payment of any required contribution.

2.02 Dependent Eligibility

Eligible dependents of a subscriber will be eligible for coverage during the same period of time the subscriber remains covered.

Eligible dependents of a retiree subscriber who were not enrolled at the time of retirement are eligible for enrollment after retirement if they have a qualifying event as outlined in Section 1.48.

2.03 Retiree Eligibility

Employees retiring after the effective date of the Plan and their dependents may, at their option and under the eligibility provision stated herein remain in the plan.

2.04 Application for Coverage

Any employee who is eligible to participate in the Plan must, during the election period, complete an enrollment form, which the Board of Trustees will furnish.

2.05 Change of Employment Status

Subject to the continuation of coverage provisions of the Plan, a participant who ceases to be an eligible employee because of a change in employment status will cease to be a participant at the end of the month in which the change occurred; except if the participant is a vested member as defined in Section 1.55 and elects to continue coverage in the Plan.

If an employee who is not eligible as a participant becomes eligible, the employee's effective date of coverage will be on the first day of the next calendar month following date of employment.

2.06 Employee Leave of Absence Without Pay

An employee who takes a leave of absence without pay, authorized by the employer, may continue to be a participant but will not be eligible for any employer contribution during that time.

2.07 Medicare Eligibility

Medicare eligibility will apply as follows:

(a) an active employee who is eligible for Medicare will continue to be a participant under the Plan unless he elects in writing to terminate plan coverage and select Medicare, at which time his dependent coverage will also terminate;

(b) an active employee's spouse reaches age 65, the spouse may choose between continuing as a participant or electing Medicare in lieu of the Plan; however, the spouse will continue to be a participant under the Plan unless the written election is received by the Board;

(c) all participants, except active employees and their dependents, will be transferred to Medicare member status under the Plan when they become eligible for coverage under Medicare; or

(d) an active employee and/or their dependents become Medicare eligible for reasons of kidney transplant or renal dialysis, Medicare will be primary payor in accordance with the Medicare guidelines.

2.08 Termination of Coverage for Subscribers

Subject to the continuation of coverage provisions, coverage by the Plan will terminate on the earliest of the following:

(a) when active employment ends, unless the individual immediately qualifies and continues to participate as a non-employee subscriber under the Plan;

(b) upon a change in employment status that no longer qualifies the employee for coverage as a subscriber;

(c) as of the date of the participant's death;

(d) non-payment of any required contributions; or

(e) the termination of the Plan.

2.09 Termination of Coverage for Retirees, Vested, Long-Term Disability or Surviving Lawful Spouse

Should a retiree's, vested member's, long-term disability recipient's or surviving lawful spouse's coverage or coverage of a participant under Article XI terminate for any reason other than death, such retiree, vested member, long-term disability recipient, surviving lawful spouse or such participant and his dependents shall not be eligible for re-enrollment, except for participants eligible for coverage when returning from active military duty and losing coverage through the military (reference Section 1.48).

2.10 Termination of Coverage for Dependents

Subject to the continuation of coverage provisions in Article XI and this section, all dependent coverage will terminate when the subscriber's coverage terminates. If a subscriber's coverage terminates because of death, dependents of a deceased subscriber may continue coverage under the Plan, providing the subscriber was enrolled in the Plan at the time of death and such dependents were covered and are eligible for coverage under the Plan. In the event the surviving spouse of a retiree does not receive a Highway and Transportation Employee's and Highway Patrol Retirement System (HTEHPRS) benefit, coverage can be continued contingent upon payment of premium.

If a surviving spouse of a deceased subscriber remarries after October 1, 1984, he and any dependents may continue coverage; however, those surviving spouses of active employees who had less than three (3) years of creditable service prior to the death of the active employee cannot continue coverage after remarriage. Dependent children of the deceased employee (retiree) may continue coverage until adoption or termination under other provisions of the Plan. Coverage will not be extended to a qualifying spouse's new spouse, or any dependents who were not covered dependents of the deceased employee (retiree) at the time of the employee's (retiree's) death.

Also, if an active employee is over age 65 and elects to terminate the Plan and select Medicare, his dependent coverage will also terminate, subject to the continuation of coverage provisions in Article XI.

Further, any dependent will cease to be covered at the earliest of:

(a) termination of dependent status;

(b) non-payment of any required contributions for such coverage;

(c) the effective date of an election or change of election which requests that the individual no longer be covered;

(d) plan termination; or

(e) death.

ARTICLE III

ELECTION AND EFFECTIVE DATE OF COVERAGE

3.01 Election of Coverage

(a) Plan Groups - The following plan groups are established to provide coverage for eligible participants.

(i) Subscriber Only – A non-Medicare subscriber

(ii) Subscriber/Spouse – A non-Medicare subscriber and spouse

(iii) Subscriber/Family – Subscriber with spouse and one or more child dependents or subscriber with three or more child dependents

(iv) Subscriber/Child – Subscriber and one child

(v) Subscriber/2 Children – Subscriber and two children

(vi) Medicare Member – An individual as defined in Section 1.33

(b) Each subscriber will be entitled to elect one of the plan groups provided the required subscriber contributions are paid. At the time the subscriber elects such coverage, he will specify the number of dependents covered, their names, date of birth, relationship and whether they are Medicare eligible.

(c) Special Situations -

(i) Two subscribers employed by either MoDOT or MSHP who are married may choose to be enrolled separately each taking subscriber coverage, or enrolled jointly under subscriber/spouse or subscriber/family coverage. Each subscriber will receive a state share contribution. It will be the responsibility of the subscribers to notify their insurance representatives of their marriage to an employee or the employment of their spouse and what type of coverage they desire for themselves and any dependents.

(ii) The maximum plan rate for any plan group will not exceed the subscriber/family plan rate.

3.02 Special Enrollment Period

A Special Enrollment Period will be allowed for:

(a) a child who is born to or adopted by the subscriber, provided the subscriber enrolls the child within 30 days of date of birth or adoption;

(b) a child if the subscriber is enrolled in the subscriber/family plan prior to a new birth or adoption;

(c) the new dependents of a subscriber who marries after the election period and elects coverage prior to or no later than 30 days after such event;

(d) subscriber and dependents enrolled in the Plan prior to the subscriber's authorized military leave, if the dependents meet the dependency requirements, when the subscriber loses military coverage and makes application within 90 days of separation;

(e) dependent children where a subscriber is court ordered to provide coverage upon receipt of a copy of the court order;

(f) employee, work-related disability recipients and dependents who lose eligibility under other insurance because:

(i) they are no longer eligible for coverage under spouse's plan;

(ii) spouse's employer-sponsored medical plan terminates;

(iii) the employer's contribution toward the spouse's plan cease;

(iv) dependent's COBRA coverage ends and, they meet the eligibility requirements of the plan; or

(v) they no longer qualify for Medicaid.

(g) dependents (of retirees, vested, long-term disability recipients, and surviving lawful spouses enrolled in the Plan) if the dependents meet the eligibility requirements of the Plan and have a qualifying event as stated in Section 1.48.

Under these provisions, an enrollment/change form (A570) is required. If the qualifying event is due to loss of eligibility as stated above, an enrollment form must be received within 60 days after other coverage ends, and documentation will be required from the previous insurance carrier or former employer stating:

(i) coverage has been terminated;

(ii) the reason for coverage termination;

(iii) list of dependents covered; and

(iv) the date coverage was terminated.

3.03 Effective Date of Coverage

(a) The effective date of coverage for a new employee will be on the first day of the next calendar month following date of employment. If the new employee was enrolled in the Plan as a dependent immediately prior to the date of employment, the creditable service requirement is waived. Effective date of coverage is subject to submission of proper application and payment of any required contribution.

(b) New employees shall have an election period of 60 days after their effective date of employment in which they may enroll themselves and their dependents.

(c) If an employee makes application for enrollment or re-enrollment more than 60 days after his effective date of employment, he could only be enrolled if he has a qualifying event as stated in Section 1.48.

(d) If an employee enrolls during his election period and elects not to enroll all eligible dependents at that time, and at a later date, he wishes to enroll such dependents, the dependents could only be enrolled if they have a qualifying event as stated in Section 1.48.

(e) Child(ren) of the subscriber born or adopted after the effective date of the subscriber's coverage under the Plan shall be covered automatically on the date of birth, or on the date of adoption, provided:

(i) the subscriber is currently enrolled in a subscriber/family plan (Enrollment Form A570 needs to be submitted); or

(ii) the subscriber enrolls the child(ren) in the appropriate plan category within 30 days of date of birth or adoption; and

(iii) payment of required contributions is received.

(f) Child(ren) of a subscriber not enrolled within 30 days of date of birth or adoption must have a qualifying event as stated in Section 1.48 to be eligible for coverage, except as stated in Section 3.03(e).

(g) If a subscriber marries after the effective date of his coverage, the spouse and/or spouse's dependents meeting eligibility requirements are eligible for coverage, if application is made prior to or within 30 days after the date of marriage to become effective on the first day of the following month.

If application is made more than 30 days from date of marriage, spouse and/or spouse's dependents must have a qualifying event as stated in Section 1.48, to be eligible for coverage. If spouse and/or spouse's dependent's have a qualifying event, coverage will be effective on the first day of the following month of receipt of enrollment form and receipt of payment of any required contributions.

Coverage will become effective on the date of marriage if application has been made, and one month's contribution received prior to the first day of the month of marriage.

(h) An employee taking leave of absence without pay authorized by the employer for purposes of military, education, maternity, illness, emergency, etc., may continue the coverage by paying the required contribution without state participation. An employee on family medical leave will receive the state contribution for 12 weeks per calendar year. If the employee terminates coverage at the time of or during a leave of absence, reinstatement of coverage will not be permitted without a qualifying event as stated in Section 1.48.

(i) An employee's coverage will not begin if they are not actively at work on the effective date due to illness or injury; coverage becomes effective on the day the employee actively returns to work. If an employee is incapacitated to such a degree that he is unable to apply for coverage during the 60-day election period, then he will be allowed a 60-day period to enroll after returning to full-time work.

(j) No change in a subscriber's plan group or change in status of a person who may be covered under the Plan shall take effect to afford coverage until on or after the first day of the next calendar month following the occurrence of all of the following events where required by the provisions of the Plan:

(i) receipt by employer of the appropriate application;

(ii) timely receipt by employer of authorization for required payroll deduction to commence as of the payroll for that month; or

(iii) receipt by employer of a manual payment where required or permitted.

3.04 Change of Plan Election

Each subscriber and their dependents currently enrolled in the Open Access III or PPO Plan, will be entitled to switch to the plan of their choice on an annual basis, during the month of October, for January 1 coverage of the following year.

If the subscriber enrolls in the Open Access III Plan, they will be allowed to switch plans mid-year with proof of change of address and employment location.

ARTICLE IV

SCHEDULE OF BENEFITS

4.01 Plan Summary of Benefits

For a summary of benefits for the PPO and Open Access III Plans, reference Appendix A (pages 26-28).

4.02 Medicare Member Benefits

Medicare members will be eligible only for the PPO Plan and for benefits described in Article VIII of the Plan.

4.03 Co-payment

Co-payments do not apply to annual deductibles or out-of-pocket maximum.

4.04 Coverage for Out-of-Country Services - Benefits are payable according to the Plan provisions. The subscriber will be responsible for filing the necessary forms for reimbursement.

4.05 Coverage for Out-of-State Services

(a) When receiving out-of-state services, present your identification card to the provider of care.

(b) If using a non-participating provider, you may be required to file the claim with the claims administrator. These benefits are generally paid at out-of-network percent co-insurance up to the benefit acceleration points (reference Appendix A, Page 26). However, the member is also responsible for any amount that exceeds the allowed amount for services rendered.

(c) Whenever possible you should wait to receive your explanation of benefits (EOB) from the claims administrator before making payment to the provider. This will allow you to make the appropriate amount of payment.

4.06 Prescription Drug Card Program

A Prescription Drug Card Program for the benefit of participants and Medicare members is provided. By using the Prescription Drug Card Program, the subscriber or Medicare member implicitly consents to the Prescription Drug Card Program Administrator having access, as needed, to the medical records of the participant or Medicare member. Restrictions and exclusions do apply for some prescriptions.

(a) A network pharmacy must be utilized for prescriptions to be covered, both in-state or out-of-state.

(b) Prescription Drug Card must be presented to the retail pharmacy at the time of purchase.

(c) Up to a 90-day prescription can be purchased through the Plan's contracted retail or mail order pharmacies.

(d) Co-insurance on prescriptions purchased at retail pharmacies and mail pharmacy will apply, with $5 minimum co-insurance payment (reference Appendix A, Page 28). The Board of Trustees may limit the co-insurance payable by the participant to a maximum level if it is deemed that a specific covered prescription drug that is a special treatment medication would pose a significant financial burden to the participant. These are special treatment(s) where the physician has little or no option in treatment, other treatment options have been exhausted, and/or the member needs the drug to treat a potentially

catastrophic or life threatening condition (i.e., organ transplant, cancer, AIDS, etc., and items related to these treatments). The drugs available under this benefit may change as new drugs become available or as drugs become available in generic formulation. Selection of special treatment drugs is at the sole discretion of the Board of Trustees. Neither the Board nor the plan will incur liability to a participant/subscriber if a drug is not selected by the Board of Trustees to be a special treatment medication.

(e) Generic medications are mandatory when available. If a brand is deemed to be medically necessary by a physician, a letter of medical necessity from the prescribing physician must be submitted to the plan administrator for review and approval of prior authorization.

If a participant insists on brand medication without an approved prior authorization, the participant will pay the brand co-insurance and the difference between the brand and generic costs of the drug, not to exceed the contract rate.

(f) Before a 90-day supply is dispensed, participants will be dispensed a starter quantity (30-day supply) on any new medications, changes on prescriptions or on prescriptions that have not been filled within the previous six months.

(g) The prescription deductible and co-insurance do not apply towards the medical deductible and co-insurance. Reference Appendix A, page 28, for prescription deductible and co-insurance amounts.

(h) The fact that a physician prescribes a specific drug does not make the drug a covered benefit. Following is a list of standard excluded drugs, which is not all inclusive:

(i) any drug that is utilized to terminate a pregnancy or possible pregnancy is specifically excluded. This includes, but is not limited to, Plan B, Preven and RU-486;

(ii) OTC products or over-the-counter equivalents and state restricted drugs (unless specifically included);

(iii) therapeutic devices or appliances such as pulmo-aid pumps, mimimed pumps, etc. (check with the medical plan administrator);

(iv) implantable time-released medication (i.e. Norplant) unless otherwise noted as stated in Section 6.01(b)(C)(4), (Zoladex is a Standard Covered Drug);

(v) experimental or investigational drugs; or drugs prescribed for experimental (non-FDA approved/unlabeled) indications (i.e. progesterone suppositories, Yocon, Erex);

(vi) drugs FDA approved for cosmetic use only (i.e. Renova, Propecia);

(vii) nutritional supplements, unless otherwise noted;

(viii) erectile dysfunction drugs;

(ix) fertility drugs;

(x) weight loss medications.

(xi) immunization agents, biological serum, vaccines, biologicals; and

(xii) extemporaneously prepared combinations of raw bulk chemical ingredients (i.e. progesterone, testosterone, or estrogen powders) or combinations of federal legend drugs in a non-FDA

approved dosage form (i.e. capsules or suppositories made from DHEA, progesterone, testosterone or estrogen powders).

(i) Some medications also require an approved prior authorization, before they are covered under the Plan. If your prescription fails to process, have your pharmacist contact the prescription drug card administrator to check why the claim did not process.

Appendix A

MoDOT/MSHP Medical Plan Summary of Benefits
Effective January 1, 2003

Listed below is a partial outline of health services covered under the MoDOT/MSHP Member Handbook or Coventry's Certificate of Coverage. This summary should not be relied upon to fully determine coverage. See the MoDOT/MSHP Member Handbook or Coventry's Certificate of Coverage for applicable limits and exclusions to coverage for these health services. If differences exist between this summary of benefits and the handbook or certificate, the handbook and certificate govern.

	PLAN 1		PLAN 2		
Benefit	**HEALTHLINK PPO PLAN Available Statewide**		**HEALTHLINK OPEN ACCESS III PLAN** Not Available Statewide See Service Area Map**		
	HealthLink PPO and Freedom Network	**Out of Network Provider***	**HealthLink HMO**	**HealthLink PPO**	**Out of Network Provider***
	Member's Responsibility				
Deductible Individual Subscriber + 1 Subscriber + 2 or more	 $300 $600 $900 maximum	 $300 $600 $900 maximum	 $0 $0 $0	 $300 $600 $900 maximum	 $500 $1,000 $1,500 maximum
Coinsurance	10%	20%	NA	20%	30%
Benefit Acceleration Point Individual Subscriber +1 Subscriber +2 or more	 $750 $1,500 $2,000	 $1,500 $3,000 $4,500	 $1,000 $2,000 $2,000	 $1,500 $3,000 $3,000	 $2,000 $4,000 $6,000
Lifetime Maximum	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Office Visit	$15 copayment for office visit only. Other services applied to deductible and coinsurance.	20% coinsurance of allowed amount after deductible	$15 copyament	$15 copayment for office visit only. Other services applied to deductible and coinsurance.	30% coinsurance of allowed amount after deductible
Immunizations	$0 copayment or %0 coinsurance of eligible expenses from birth through age five	20% coinsurance of allowed amount after deductible	$0 copayment or %0 coinsurance of eligible expenses from birth through age five	$0 copayment or %0 coinsurance of eligible expenses from birth through age five	30% coinsurance of allowed amount after deductible
Preventive Care	Member responsible for amount in excess of $100 per calendar year. (Benefit applies to active employees, work-related and long-term disability recipients and enrolled spouse only)	Member responsible for amount in excess of $100 per calendar year. (Benefit applies to active employees, work-related and long-term disability recipients and enrolled spouse only)	Member responsible for amount in excess of $350 per calendar year. (Benefit applies to subscriber and enrolled dependents.)	Member responsible for amount in excess of $350 per calendar year. (Benefit applies to subscriber and enrolled dependents.)	
Inpatient Hospital Care	10% coinsurance after deductible. Pre-admission Certification Required	20% coinsurance of allowed amount after deductible. Pre-admission Certification Required.	0% of eligible expenses. Pre-admission Certification Required.	20% coinsurance after deductible. Pre-admission Certification Required.	30% coinsurance after deductible. Pre-admission Certification Required.
Urgent Care	$15 copayment for office visit only. Other services applied to deductible and coinsurance.	20% coinsurance of allowed amount after deductible.	$35 copayment	$25 copayment for office visit only. Other services applied to deductible and coinsurance.	30% coinsurance of allowed amount after deductible. Other services applied to deductible and coinsurance.
Surgery	10% coinsurance after deductible. Pre-admission Certification Required.	20% coinsurance of allowed amount after deductible. Pre-admission Certification Required.	0% of eligible expenses. Pre-admission Certification Required.	20% coinsurance after deductible. Pre-admission Certification Required.	30% coinsurance of allowed amount after deductible. Pre-admission Certification Required.
Allergy Injections	10% coinsurance after deductible.	20% coinsurance of allowed amount after deductible.	$15 copayment with office visit; $5 per injection w/o office visit	20% coinsurance after deductible	30% coinsurance of allowed amount after deductible

Appendix A

Benefit	PLAN 1 HEALTHLINK PPO PLAN *Available Statewide*		PLAN 2 HEALTHLINK OPEN ACCESS III PLAN** Not Available Statewide *See Service Area Map*		
	HealthLink PPO and Freedom Network	Out of Network Provider*	HealthLink HMO	HealthLink PPO	Out of Network Provider*
	Member's Responsibility				
Emergency Room Services	$75 copayment and 10% coinsurance after deductible. Copayment waived if admitted or accidental injury.	$75 copayment and 20% coinsurance of allowed amount after deductible. Copayment waived if admitted or accidental injury.	$75 copayment. Copayment waived if admitted or accidental injury.	$75 copayment and 20% coinsurance after deductible. Copayment waived if admitted or accidental injury.	$75 copayment and 30% of allowed amount after deductible. Copayment waived if admitted or accidental injury.
Maternity	10% coinsurance after deductible.	20% coinsurance of allowed amount after deductible.	$15 copayment for initial visit. All other prenatal visits, deliver cots and routine post-natal visits covered at 100%	20% coinsurance after deductible.	30% of coinsurance of allowed amount after deductible.
Chiropractic Services	10% coinsurance after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	20% coinsurance of allowed amount after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	$10 copayment; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	20% coinsurance after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	30% coinsurance of allowed amount after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.
Mental Health (MH)/ Chemical Dependency (CD) – Inpatient	10% coinsurance after deductible; 30 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	20% coinsurance of allowed amount after deductible; 30 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	Available at PPO and out of network level of benefits only.	20% coinsurance after deductible; 30 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	30% coinsurance of allowed amount after deductible; 30 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.
Mental Health (MH)/ Chemical Dependency (CD) – Outpatient	Outpatient office visit: $15 copayment; outpatient hospital: 10% coinsurance after deductible; 20 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	20% coinsurance of allowed amount after deductible; 20 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	Available at PPO and out of network level of benefits only.	Outpatient office visit: $15 copayment; outpatient hospital: 20% coinsurance after deductible; 20 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	30% coinsurance of allowed amount after deductible; 20 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.
Organ Transplant Coverage (Not Through HealthLink)					
Organ Transplants (Network affiliation is determined through the Organ Transplant Carrier)	100% coverage for transplant and 18 months following the transplant within transplant carrier's network.	20% of network cost to the closest in-network facility within transplant carrier's network plus the difference between the network and actual cost.	100% coverage for transplant and 18 months following the transplant within transplant carrier's network.	100% coverage for transplant and 18 months following the transplant within transplant carrier's network.	20% of network cost to the closest in-network facility within transplant carrier's network plus the difference between the network and actual cost.

Appendix A

Benefit	PLAN 1 HEALTHLINK PPO PLAN *Available Statewide*		PLAN 2 HEALTHLINK OPEN ACCESS III PLAN** Not Available Statewide *See Service Area Map*		
	HealthLink PPO and Freedom Network	Out of Network Provider*	HealthLink HMO	HealthLink PPO	Out of Network Provider*
	Member's Responsibility				
Pharmacy Benefit – Available Through Eckerd Participating Pharmacies Only					
Deductible	$75		$0		
Generic	30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment.		20% coinsurance at retail and mail order pharmacy with $5 minimum copayment.		
Brand	**If a generic is available:** 30% coinsurance of brand drug's cost plus the difference between the brand and generic after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment. **If no generic is available:** 30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment. **If brand is medically necessary and approved by Eckerd:** 30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment.		**If a generic is available:** 20% coinsurance of brand drug's cost plus the difference between the brand and generic at retail and mail order pharmacy with $5 minimum copayment. **If no generic is available:** 20% coinsurance at retail and mail order pharmacy with $5 minimum copayment. **If brand is medically necessary and approved by Eckerd:** 20% coinsurance at retail and mail order pharmacy with $5 minimum copayment.		

* Out of Network Provider service insurance payments are subject to Usual and Customary Rates (UCR) only. The Member will be 100% responsible for amounts above UCR.

** HealthLink must be notified prior to any outpatient surgery, diagnostic and ancillary services and also prior to any elective hospital admission. Please have admitting physician or member call HealthLink, Inc. toll-free at (877) 284-0102.

ARTICLE V

SPECIAL INCENTIVE BENEFITS

5.01 General Information

The features listed in this section are included in the Plan in order to provide incentives for participants to use cost-effective forms of treatment on a voluntary basis. No penalties apply for failure to use the special features described in this section.

5.02 Pre-Admission Testing

The deductible will be waived, and the Plan will pay 100 percent of allowed amounts for testing performed on an outpatient basis prior to a hospital admission for a scheduled surgical procedure that is a covered service, provided admission occurs within ten days and the tests are not repeated when the participant is admitted for the surgery and the surgery is performed.

5.03 Large Case Management

A participant who requires long-term care may be offered the option of receiving the care in a more cost effective setting, such as a skilled nursing facility or the participant's own home, if the utilization review organization, acting according to principles that preclude individual selection, determines that such an alternative method of delivery is appropriate for the participant's condition.

When the utilization review organization offers the participant a choice of setting, the offer will be set forth in writing and will specify the service and/or items of care that the Plan will cover. Under these circumstances, the benefits of the Plan may be expanded to meet the specific medical needs of the participant.

The participant will have no obligation to accept any alternative delivery system that may be offered. If the participant refuses the offer, plan benefits will be paid.

In the case of a participant who is a minor or whom the utilization review organization considers incapable of making a decision on his own behalf, the utilization review organization will make the offer to the parent or their nearest relative. Such parent or relative will have the right to accept or refuse on behalf of the participant.

ARTICLE VI

COVERED SERVICES AND EXCLUSIONS

6.01 Covered Services

The following are covered services in an amount up to the allowed amount. In order to be covered the services must be medically necessary and are subject to all other exclusions and limitations contained in the Plan.

(a) Hospital Services

(i) Inpatient or outpatient hospital services and supplies.

(A) Bed, board, and general nursing service when a participant occupies:

(1) a room with two or more beds, known as a semi-private room or ward;

(2) a private room. The allowed amount for a private room is an allowance equal to the hospital's most common semi-private room rate, unless a private room is the only room available or is required for medical reasons; or

(3) a bed in an intensive care unit.

(B) Ancillary hospital services and supplies including, but not restricted to:

(1) use of operating, delivery, and treatment rooms and equipment;

(2) pharmacy services and supplies;

(3) administration of blood and blood processing (including the cost of blood, plasma, or fractionalized blood products);

(4) anesthesia, anesthesia supplies and services rendered by an employee of the hospital or through approved contractual arrangements;

(5) medical and surgical dressings, supplies, casts, and splints;

(6) diagnostic services;

(7) therapy services; or

(8) nursing services in an intensive care unit, other than the portion referenced in Section 6.01 (a)(i)(A).

(b) Surgical/Medical Services

(i) Surgical Services

Surgery performed by a physician, including normal pre-operative and post-operative care.

(A) Single Surgical Services

The allowance for a single surgical service will be the allowed amount. When surgical services are concurrently rendered by two or more physicians, the payment will be the same as if rendered by one physician.

(B) Multiple Surgical Services

The allowance for concurrent, successive, or other multiple surgical services will be limited to:

(1) two or more surgical services performed at the same time for related conditions, the total allowance will be that of the major surgical service only;

(2) two or more unrelated surgical services performed at the same time, the total allowance will be equal to the amount of the surgical procedure that has the greatest allowance, plus one-half of the allowance specified for each of the other surgical services performed; or

(3) the allowance for two or more separate, distinct and unrelated surgical services performed at different times will be the allowed amount for each surgical service.

(C) Special Surgery

Special surgeries are limited to:

(1) reconstructive surgery, while a participant in the Plan to correct:

(a) a disfiguration of the face or hands;

(b) reconstructive surgery of a diseased breast upon which surgery was performed;

(c) surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, with no time limit imposed on reconstructive surgery; or

(d) for the grafting of skin to any other part of the body;

(2) elective surgery and related medical treatment provided such surgery or treatment is necessary to reduce or eliminate a physical endangerment to the participant's health;

(3) elective sterilizations will be a covered service for subscribers and their spouse; or

(4) implantation of contraceptive devices and injectables not covered under the prescription drug program will be covered at the co-insurance benefit level outlined in your pharmacy benefit. Benefit acceleration point(s) will not be applicable with regard to these services. This includes, but is not limited to, Norplant and IUD's.

(D) Human Organ and Tissue Transplants

Charges for human-to-human eye transplants, including the expenses of the donor. This is in addition to the transplant benefits contained in Section 7.01.

(E) Anesthesia

Administration of anesthesia ordered by the attending physician and rendered by a physician or other professional provider.

(ii) Inpatient Medical Services

Care rendered by a physician or other professional provider to a participant who is a hospital inpatient for a condition not related to surgery or an obstetrical procedure.

(A) Concurrent Care

(1) Care rendered concurrently with surgery during a hospital stay by a physician other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed.

(2) Care rendered by two or more physicians concurrently during a hospital stay for separate medical conditions when the nature or severity of the participant's condition requires the skills of separate physicians.

(B) Consultation

Consultation services rendered to a participant by another physician at the request of the attending physician. Consultation does not include staff consultations that may be required by hospital rules and regulations.

(iii) Outpatient Medical Services

Care rendered by a physician or other professional provider to a participant who is an outpatient for a condition not related to surgery or an obstetrical procedure.

(c) Diagnostic Services

(d) Therapy Services – Refer to Section 1.52 or check with the claims administrator for coverage of therapy services.

(e) Obstetrical Services

Obstetrical care and care for conditions of pregnancy for the subscriber or the enrolled lawful spouse of a subscriber. Routine nursery care, including circumcision will also be considered if billed to the newborn child who is enrolled in the Plan (reference Section 3.03 (e)). Routine nursery care is limited to the length of the mother's hospital stay.

(f) Psychiatric Care Services

Services for the treatment for mental health when rendered by an appropriate provider.

(i) Inpatient Psychiatric Care Services

Inpatient hospital services and inpatient medical care for the treatment for mental health. Benefits are also provided for:

(A) individual psychotherapy treatment;

(B) group psychotherapy treatment;

(C) psychological testing; or

(D) electroshock treatment or convulsive drug therapy, including anesthesia.

(ii) Day/Night Psychiatric Care Services

The treatment for mental health in an approved therapeutic treatment program when such services are rendered during the day only or during the night only.

(iii) Outpatient Psychiatric Care Services

The outpatient treatment for mental health when rendered by a hospital, physician, or other appropriate provider.

(iv) Services and medical care for the treatment for mental health conditions will be provided on the same basis as the services and medical care for physical conditions except for:

(A) inpatient hospital services and inpatient medical care for the treatment of alcohol and other drug abuse shall have a thirty (30) day maximum per plan year (inpatient treatment may be converted for outpatient use on a two-for-one basis);

(B) outpatient services and treatment for alcohol and other drug abuse shall have a twenty (20) day maximum per plan year; and

(C) lifetime maximum is four (4) times the plan year maximum for alcohol and drug abuse.

(g) Ambulance Services

Ambulance service providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

(i) from a participant's home or scene to a hospital when emergency care is necessary;

(ii) between hospitals; or

(iii) to or from a medical clinic.

Benefits will be paid for air ambulance services to the nearest hospital capable of providing medically necessary treatment when ground transportation would endanger the safety of the participant.

(h) Private Duty Nursing Services

Private duty nursing services performed by an actively practicing private duty nurse when prescribed by a physician and limited to the time such services are deemed medically necessary.

(i) Dental Services

(i) Accidental Injury

Dental services rendered by a physician and required as a result of accidental injury to the jaws, sound natural teeth, mouth or face, including the replacement of such teeth, provided such accident and the repair services occur while the participant's coverage is in effect. Injury as a result of chewing or biting is not considered an accident.

(ii) Other dental services include:

(A) the excision of impacted teeth;

(B) other incision or excision procedures performed on the gums or tissues of the mouth, but not performed in connection with the extraction or repair of teeth; and

(C) the diagnosis and treatment of temporomandibular joint (TMJ) syndrome or dysfunction; except that biofeedback, orthodontics, equilibration of the teeth, behavior modification techniques or training, orthodontic braces, crowns, or dentures for the treatment of TMJ syndrome, and jaw or facial x-rays in connection with such exceptions, are not covered services under the Plan.

(j) Durable Medical Equipment

Rental of durable medical equipment or surgical equipment if deemed medically necessary. These items may be bought or rented, with the cost not to exceed the fair market value of the equipment, but only if agreed to in advance by the plan administrator.

Durable medical equipment is limited to the following and other equipment approved from time to time by the Board of Trustees:

(i) trusses; crutches; and braces;

(ii) equipment for the administration of oxygen;

(iii) a wheelchair or hospital type bed;

(iv) an iron lung;

(v) electronic heart pacemaker; or

(vi) TENS unit (with approved letter of medical necessity).

Repair, replacement or maintenance is covered when there is sufficient change in the covered person's physical condition to make the original device no longer functional.

(k) Prosthetic Appliances

The initial purchase, fitting, and necessary adjustments of prosthetic devices and supplies that replace all or part of an absent body organ or limb, (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb. A time limit cannot be imposed for prosthetic appliances received for a mastectomy; and if the mastectomy was not performed while a participant was enrolled in the plan, the prosthetic appliance must be provided.

Repair, replacement or maintenance is covered when there is sufficient change in the covered person's physical condition to make the original device no longer functional.

The following appliances are excluded:

(i) electrical continence aids, either anal or urethral;

(ii) implants for cosmetic or psychological reasons;

(iii) penile prostheses for psychogenic impotence;

(iv) dental appliances;

(v) replacement of cataract lenses except when new cataract lenses are needed because of prescription change;

(vi) remote control devices;

(vii) devices employing robotics; or

(viii) all mechanical organs.

(l) Orthotic Devices

The initial purchase and fitting of orthotic appliances such as braces, splints or other appliances which are required for support of an injured or deformed part of the body as a result of a disabling congenital condition or an injury or sickness, excluding the following:

(i) arch supports and other foot support devices;

(ii) elastic stockings;

(iii) garter belts;

(iv) orthopedic shoes; or

(v) special braces.

Repair, replacement or maintenance is covered when there is sufficient change in the covered person's physical condition to make the original device no longer functional.

(m) Administrative Costs

The completion and filing of claim forms, medical reports, and invoices by a physician or hospital.

(n) Chiropractic Services

The manual manipulation of the spine by a licensed chiropractor to correct a subluxation. The plan allows coverage for one X-ray by a chiropractor per calendar year. Covered services for manual manipulations will be limited to 30 treatments per calendar year.

(o) Therapeutic Abortion

Only when the life of the mother would be endangered if the fetus were carried to term. Includes treatment of the complications of any abortion. Further, these covered services are only available to a participant who is the subscriber or the lawful spouse of a subscriber.

(p) Mammograms

Coverage for any nonsymptomatic woman covered under the plan is provided as follows:

(i) a baseline mammogram for women age 35 to 39, inclusive;

(ii) a mammogram for women age 40 to 49, inclusive; every two years or more frequently based on the recommendation of the patient's physician;

(iii) a mammogram every year for women age 50 and over;

(iv) a mammogram for any woman, upon the recommendation of a physician, where such woman, her mother or her sister has a prior history of breast cancer; and

(v) office visit related to mammogram.

Coverage and benefits to mammography shall be subject to the same dollar limits, deductibles and co-payments as other radiological examinations.

(q) Well-Baby and Well-Child Checks

Includes normal, periodic immunizations and examinations through 5 years of age. This service is covered at 100% and is not subject to deductible. Reference Section 6.01(r) for additional immunization coverage over age 5 years.

(r) Immunizations

For enrolled participants 6 years of age or older, coverage will be provided for immunizations according to the schedule of "Recommended Childhood Immunization United States, January-December 2000". The Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) has approved this schedule, (reference Appendix B – (Pages 42,43).

In addition, coverage will be provided for Pneumococcal Conjugate Vaccine (Prevnar) according to recommendations from the AAP. Immunizations should be discussed with your physician. Generally, coverage is provided in accordance with Appendix B, (Pages 43, 44).

Hepatitis B vaccines have recently become a requirement for many employers and schools; therefore, no age restriction will be implemented for Hep B.

These immunizations will be covered at 100 percent of the allowable amount if received in network. Out-of-network claims will be subject to allowed amount(s), deductible(s) and co-insurance. Office visit charges associated with the immunizations will be paid in accordance with the $15 co-insurance for a PPO provider. Deductible(s), co-insurance, and all other plan guidelines will apply when utilizing a non-PPO provider. Reference Section 6.01(q) for additional immunization coverage for children under age 5 years.

(s) Newborn Screening, Diagnosis and Treatment

Every infant shall have the following coverage:

(i) phenylketonuria (PKU) and such other metabolic or genetic disease as prescribed by the Department of Health;

(vi) special dietary products for treatment of metabolic and genetic diseases who is less than six (6) years of age;

(vii) formula for the treatment of inherited diseases of amino acids and organic acids;

(viii) potentially treatable or manageable disorders, including cystic fibrosis, galactosemia, biotinidase deficiency, congenital adrenal hyperplasia, maple syrup urine disease (MSUD) and other amino acid disorders, glucose-6-phosphate degydrogenase deficiency (G-6-PD), MCAD and other fatty acid oxidation disorders, methylmalonic academia, propionic academia, isovaleric academia and glutaric academia Type I;

(ix) newborn hearing screening, necessary re-screening, audiological assessment and follow-up, and initial amplification. If delivered in an ambulatory surgical center or hospital, the newborn must be screened prior to discharge. If delivered in a place other than an ambulatory surgical center or hospital, the screening must be performed within three (3) months of the date of birth. Covered physiological technologies are: automated or diagnostic auditory brianstem response (ABR); otoacoustic emissions (OAE) or other technologies approved by the Department of Health; and

(x) office visit related to newborn screening.

(t) Emergency Room Services

Eligible expenses incurred for treatment rendered in a hospital's emergency room will be payable on the same basis as any other illness or injury after satisfaction of a separate $75 emergency room co-payment. This emergency room co-payment must be satisfied each time a covered individual receives emergency room services, and must be satisfied in addition to the plan's calendar year deductible and co-insurance. The emergency room co-payment will be waived if the emergency room visit is necessitated by an accident or injury or if the patient is admitted as a hospital inpatient directly from the emergency room.

(u) Cancer Screenings

Cancer screenings shall include the following screenings and office visits related to the screening, (coverage for office visits is effective January 1, 2003):

(i) an annual pelvic exam and pap smear for any nonsymptomatic woman age 18 and over;

(ii) a prostate exam and PSA blood test for any nonsymptomatic man over the age of 50 or for younger men who are at high risk and/or have a family history of prostate cancer; or

(iii) men and women age 50 or older or if a doctor prescribes at a younger age because of high risk or family history:

(A) a fecal occult blood test every year and sigmoidoscopy every 5 years;

(B) a colonoscopy every 10 years;

(C) double-contrast barium enema every 5 to 10 years; or

(D) a digital rectal exam, sigmoidoscopy, colonoscopy or barium test.

These screenings are subject to usual deductibles and co-insurance if processed under regular medical benefits; however, they can also be processed as preventive care. (reference Appendix A, page 26).

(v) Equipment, Supplies and Self-Management Training for Diabetes

Coverage for diabetes is as follows:

(i) office visit;

(ii) equipment and supplies not covered under the prescription drug card program;

(iii) self-management training used in the management and treatment of diabetes; and

(iv) subject to usual deductibles and co-insurance.

Coverage shall include persons with gestational, Type I or Type II diabetes.

(w) Osteoporosis

Coverage for services, including office visits, related to diagnosis, treatment and appropriate management for enrollees with a condition or medical history for which bone mass measurement is medically indicated.

(x) Lead Poisoning Testing

Lead poisoning testing shall include:

(i) testing of pregnant women for lead poisoning;

(ii) testing of all children, enrolled in the plan, less than six (6) years of age; and

(iii) related office visit.

Coverage for testing shall be in accordance with the provisions of the Department of Health's Childhood Lead Testing Program.

6.02 Exclusions

The services and supplies specified in this section will not be considered covered services.

(a) Services or supplies provided for dental services, except as provided in Section 6.01(i).

(b) Services or supplies provided before the coverage date or after coverage under the Plan ends.

(c) Services and supplies and days of care that are not medically necessary for the diagnosis or treatment of an injury, illness, or symptomatic complaint. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge a covered service, even though the service or supply is not specifically listed as an exclusion. The authority for determining whether services or supplies or days of care are medically necessary lies with the claims administrator.

(d) Services and supplies for any condition, disease, ailment or accidental injury arising out of and in the course of employment if benefits or compensation is available, in whole or in part, under any worker's compensation or occupational disease statutes or other similar law (the "Statutes"). This exclusion applies whether or not the participant claims the benefits or compensation and whether or not the participant recovers compensation from any third party. However, if a dispute arises between the participant and the insurance carrier for any coverage under one of these Statutes, the Plan may pay the covered services, pending settlement of the workers' compensation claims, and if the insurance carrier for benefits or compensation under these Statutes should later be held responsible, the participant or carrier would be required to reimburse the Plan.

(e) Treatment in any sanatorium or any state or federal hospital, including any Veterans Administration hospital, for military service-related medical expenses, or services and supplies for which the participant is eligible or for which benefits are available under any governmental health plan besides Medicaid, except to the extent required under existing state or federal laws and regulations.

(f) Any hospital service or supply not ordered by a physician.

(g) Charges in excess of the allowed amount, or in excess of the value of the service or supply as determined by the claims administrator.

(h) The services of a provider who ordinarily resides in the participant's home or is a member of the participant's immediate family.

(i) Services and supplies for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war, for military personnel or others while participating in the armed forces and covered under other medical insurance.

(j) Expenses in connection with cosmetic or transplant surgery, except as provided in Sections 6.01(b)(i)(C) and (D) and Article VII.

(k) Expenses incurred for and in connection with procedures, drugs, or devices that are considered by the claims administrator to be experimental/investigative.

(l) Hearing aids, routine hearing tests and audiograms.

(m) Eyeglasses, contact lenses, and examinations, whether or not prescribed, except for prosthetic lenses or sclera shells following intra-ocular surgery. Replacement of cataract lenses is also excluded, except when new cataract lenses are needed because of a prescription change.

(n) Services and supplies for personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, or physical fitness equipment; and personal items such as a TV, telephone, cots, and visitors' meals.

(o) Services in connection with the treatment of:

(i) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except for open cutting operations or laser surgery; or

(ii) corns, callouses, toenails, except for the partial or complete removal of nail roots or for services prescribed by a physician who is treating the participant for metabolic peripheral vascular disease.

(p) Health examinations (including X-rays, laboratory tests and routine preventive immunizations), except as provided in preventive care provisions or well-baby and well-child checks.

(q) Services and supplies in rest homes, health resorts, homes for the aged, or places primarily for domiciliary or custodial care, except as otherwise specifically provided.

(r) Services for or in connection with custodial care, education or training of the participant, whether or not prescribed by a physician, except as otherwise specifically provided.

(s) Services not specified as covered. Non-traditional medical services, treatments and supplies, which are not specified as covered under the Plan. These services, treatments and supplies, etc. include, but are not limited to the following:

(i) acupuncture, acupressure, hypnosis;

(ii) biofeedback therapy;

(iii) blood pressure cuff;

(iv) donor expenses for obtaining blood from a blood bank or supplier; or

(v) massage therapy (except as provided under Section 1.44 (j)).

(t) Circumcision if not performed within 30 days of birth except when medically necessary.

(u) Drugs, medicines, vitamins, minerals and tonics purchased for use outside of a hospital for which a written prescription is not required.

(v) Services and supplies for which the participant has no legal obligation to pay.

(w) Services and supplies rendered prior to the effective date of the plan or after the termination date of the plan, or services and supplies rendered prior to the participant's coverage date or after the participant's termination date.

(x) Transportation charges, except as covered under ambulance services.

(y) Injuries or illnesses resulting from taking part in the commission of a felony.

(z) Services or supplies for reversal of voluntary sterilization. Services or supplies related to sex transformation, sexual therapy or counseling, or sexual dysfunctions or inadequacies except conditions resulting from injury or organic disease.

(aa) Weight reduction programs or treatment for obesity and any surgery for removal of excess fat or skin following weight loss due to obesity surgery or pregnancy, regardless of medical necessity, or services at a health spa or similar facility.

(bb) Services and supplies in connection with organ and tissue transplants, except as provided in Section 6.01(b)(i)(D) and Article VII.

(cc) Services in connection with the treatment of fertility or infertility.

(dd) Services and supplies for conditions related to autistic disease of childhood, milieu therapy, learning disabilities, mental retardation, or for inpatient admission for environmental change.

(ee) Services rendered by non-covered providers, including, but not limited to, the following providers and facilities:

(i) naturopaths;

(ii) licensed counselors (except as specifically provided in Section 1.44);

(iii) mid-wives;

(iv) marital counselors; or

(v) sanatoriums.

(ff) Services in connection with an abortion, except as provided in Section 6.01(o).

(gg) Taxes on covered expenses such as crutches, braces, etc., that the participant purchases.

(hh) Chiropractic services, except as specifically provided in Section 6.01(n).

(ii) Services or supplies not specifically listed as covered.

(jj) Services and supplies for treatment not rendered in accordance with locally acceptable standards of medical practice, as determined by the claims administrator.

(kk) Long-term physical therapy and rehabilitation or other physical therapy or rehabilitation when, in the judgment of the Board, no significant improvement has occurred or is likely to occur.

(ll) Diagnostic admissions.

(mm) Services or supplies rendered or prescribed by a provider outside the scope of his or its license.

(nn) Repair, replacement or maintenance of durable medical equipment, prosthetics or braces unless there is sufficient change in the participant's physical condition to make the original device no longer functional.

(oo) Services for obstetrical care and care for conditions of pregnancy for any participant other than the subscriber or the enrolled lawful spouse of the subscriber.

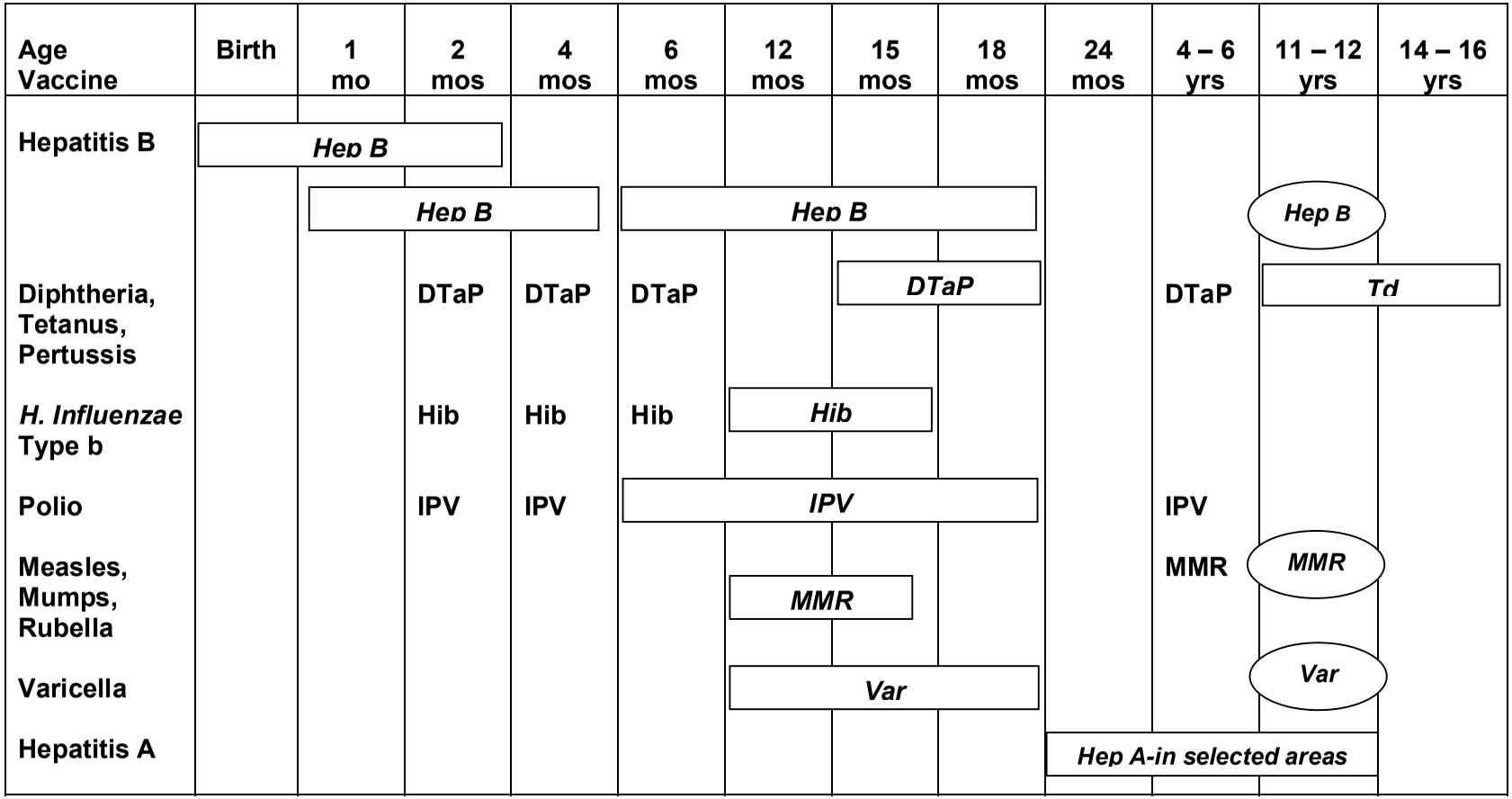
(pp) Services and supplies in connection with gastric bypass surgery (effective 6/01/03).

(qq) Services and supplies rendered by a Christian Science Sanatorium accredited by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, or an institution of substantially similar nature to that operated by the First Church of Christ, Scientist; or comparable spiritual organizations (effective 6/01/03).

Appendix B

Recommended Childhood Immunization Schedule
United States, January – December 2000

Vaccines are listed under routinely recommended ages. Bars indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.



Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

TABLE 1

*Recommended Schedule of Doses for PCV7, Including Primary Series and Catch-Up Immunizations, in Previously Unvaccinated Children**

Age at First Dose	Primary Series	Booster Dose [+]
2 – 6 months	3 doses, 6-8 wk apart	1 dose at 12-15 mo of age
7 – 11 months	2 doses, 6-8 wk apart	1 dose at 12-15 mo of age
12-23 mo	2 doses, 6-8 wk apart	
≥ 24 mo	1 dose	

*Recommendations for high-risk groups are given in Table 3.

[+]Booster doses to be given at least 6 to 8 weeks after the final dose of the primary series.

TABLE 2

Children at High Risk of Invasive Pneumococcal Infection

High Risk (attack rate of invasive pneumococcal disease >150/100,000 cases/y) 1. SCD, congenital or acquired asplenia, or splenic dysfunction 2. Infection with HIV
Presumed high risk (attack rate not calculated) 1. Congenital immune deficiency: some B- (humoral) or T-lymphocyte deficiencies, complement deficiencies (particularly C1, C2, C3 and C4 deficiencies), or phagocytic disorders (excluding chronic granulomatous disease) 2. Chronic cardiac disease (particularly cyanotic congenital heart disease and cardiac failure) 3. Chronic pulmonary disease (including asthma treated with high-dose oral corticosteroid therapy) 4. Cerebrospinal fluid leaks 5. Chronic renal insufficiency, including nephrotic syndrome 6. Diseases associated with immunosuppressive therapy or radiation therapy (including malignant neoplasms, leukemias, lymphomas, and Hodgkin's disease) and solid organ transplantation* 7. Diabetes mellitus
Moderate risk (attack rate of invasive pneumococcal disease >20 cases/100,000/y) 1. All children 24-35 mo old 2. Children 36-59 mo old attending out-of-home care 3. Children 36-59 mo old who are of Native American (American Indian and Alaska Native) or African American descent

*Guidelines for the use of pneumococcal vaccines for children who have received bone marrow transplants are currently undergoing revision (Centers for Disease Control and Prevention, personal communication, 2000)

TABLE 3

Recommendations for Pneumococcal Immunization With PCV7 or 23PS Vaccine for Children at High Risk of Pneumococcal Disease, as Defined in Table 2.*

Age	Previous Doses	Recommendations
≤23 mo	None	PCV7 as in Table 1
24-59 mo	4 doses of PCV7	1 dose of 23PS vaccine at 24 mo, at least 6-8 wk after last dose of PCV7
		1 dose of 23 PS vaccine, 3-5 y after the first dose of 23PS vaccine
24-59 mo	1-3 doses of PCV7	1 dose of PCV7
		1 dose of 23PS vaccine, 6-8 wk after the last dose of PCV7
		1 dose of 23 PS vaccine, 3-5 y after the first dose of 23PS vaccine
24-59 mo	1 dose of 23PS	2 doses of PCV7, 6-8 wk apart, beginning at least 6-8 wk after last dose of 23PS vaccine
		1 dose of 23PS vaccine, 3-5 y after the first dose of 23PS vaccine
24-59 mo	None	2 doses of PCV7 6-8 wk apart
		1 dose of 23PS vaccine, 6-8 wk after the last dose of PCV7
		1 dose of 23PS vaccine, 3-5 y after the first dose of 23 PS vaccine

**Children with SCD, asplenia, HIV infection, and other high-risk factors.*

ARTICLE VII

HUMAN ORGAN TRANSPLANT INSURANCE

7.01 As part of the Plan, the Board has purchased human organ transplant insurance for the benefit of participants. This is in addition to the transplant benefits contained in Section 6.01(b)(i)(D).

Benefits under the insurance policy are restricted solely to the coverage provided by such policy and not otherwise. The policy will be paid for by plan funds and the terms of such policy may change from time to time.

ARTICLE VIII

MEDICARE MEMBER PROVISIONS

8.01 Eligibility

The Medicare member provisions of the Plan apply to the following participant classes:

(a) retirees and their dependents;

(b) vested members and their dependents;

(c) surviving spouses and their dependents; and

(d) long-term, and work-related disability recipients and their dependents.

Medicare member provisions do not apply to employees and their dependents.

Plan benefits for covered services received on and after the date Medicare member status begins will be paid according to the terms of this Article.

8.02 Deductible

The deductible will be $300 per calendar year per Medicare member. It applies to all covered services rendered to the Medicare member, in addition to a separate calendar year deductible of $50 for Private Duty Nursing Services, and a $75 calendar year deductible for the Prescription Drug Card Program.

Amounts credited toward a participant's deductible under the non-Medicare provisions of the Plan in the calendar year in which the participant becomes a Medicare member will be credited toward the Medicare member deductible, subject to the proper submission of a claim.

8.03 Benefits

The Medicare member benefits of the Plan are designed to supplement the benefits of Parts A and B of Medicare. For purposes of calculating Medicare member benefits under the Plan, each Medicare member will be deemed to be enrolled in both Part A and Part B of Medicare, and no plan benefits will be paid for services covered by Medicare Part B if the Medicare member is not enrolled in Medicare Part B.

Once the Medicare approved amount has been determined, the claim is reduced by the amount payable by Medicare. On Medicare assigned claims, benefits are paid up to the Medicare approved amounts. On Medicare nonassigned claims, benefits are paid up to the lesser of the provider's actual fee or the allowed amount for the type of services rendered.

Prescription benefits, which are not covered by Medicare Parts A or B, will be covered under this Plan as stated in the guidelines of the Plan document. Reference Section 4.06 and Appendix A, Page 28.

Other specific benefits the Plan will cover include the first three (3) pints of blood, which are not covered by Medicare Parts A and B; and one (1) x-ray of the spine by a chiropractor per calendar year subject to your annual deductible and co-insurance requirements under the Plan.

8.04 Coordination of Benefits

If a Medicare member receives benefits from any other group health plan that is intended to supplement Medicare, the Plan will coordinate its benefits with those of the other health plan as described in Article X; provided, however, the Plan will always calculate its Medicare member benefits after Medicare has paid.

8.05 Services by Non-Medicare Provider

If a Medicare member is confined in a hospital or treated by a provider that does not participate in Medicare, and if Medicare benefits are not recoverable by individual filing, plan benefits for such confinement or treatment will be calculated under the regular non-Medicare member provisions of the Plan. If Medicare benefits are recoverable by individual filing, plan benefits for such confinement or treatment will be calculated according to these Medicare member provisions. The responsibility for filing the forms necessary for Medicare reimbursement will be with the Medicare member.

8.06 Coverage for Out-of-Country Services - Benefits are payable as stated in Section 8.05.

ARTICLE IX

COST CONTAINMENT

9.01 General Information

The requirements listed in this Article are incorporated into the Plan to reduce or eliminate costs for services and supplies not provided in a cost-effective manner.

Pre-certification is required for non-emergency hospital admissions for the PPO Plan and for non-emergency hospital admissions and outpatient services for the Open Access III Plan. You, your physician, or facility must call the pre-certification telephone number listed on your medical insurance card for pre-approval for all services requiring pre-certification. Pre-certification is also required for emergency hospital admissions and/or outpatient emergency care. The Utilization Review Organization must be notified within 48 hours or on the next working day, if later.

Failure to obtain pre-certification will result in a 20 percent penalty (not to exceed $1,000) of the total allowed amount before plan benefits are determined. The penalty will be assessed on each occurrence where pre-certification is required but not obtained. Pre-certification is not a verification of benefits. Plan guidelines for benefit determination will apply to all claims including those requiring pre-certification. 100 percent of costs incurred for services not covered by the Plan for any reason will be deducted before plan payment is determined.

The participant's share of the medical expenses resulting from the 20 percent penalty will not apply to deductibles or the benefit acceleration point. Ultimately, it is the subscriber's responsibility to assure pre-certification has been obtained.

The Board of Trustees will appoint a utilization review organization to evaluate medical records required in the determination of issues such as medical necessity, appropriate length of stay, and medical complexity.

The Board of Trustees, claims administrator, and the utilization review organization are only providing benefits in accordance with the Plan and their determinations as to benefits are not intended to control the decisions of the participant's provider. Accordingly, they are not responsible for the quality or availability of services or supplies received by participants.

9.02 Pre-Admission Certification and Concurrent Review Requirements

(a) PPO Plan

(i) Elective hospital admissions, except those for obstetrical care, must be approved by the utilization review organization in advance. Elective admissions are defined as admissions that do not involve emergency care.

(ii) Elective hospital admissions will not be approved for any Saturday, Sunday, or nationally recognized legal holiday that occurs on Friday or Monday unless, on the day of admission, the participant receives medically necessary services that can only be rendered in a hospital and cannot be postponed.

(iii) Further, admission will not be approved for the day before a surgical procedure is scheduled to be performed unless, on the day of admission, the

participant receives medically necessary services that can only be rendered in a hospital.

(iv) When an admission is approved, the utilization review organization will determine a length of stay appropriate to the nature and severity of the participant's condition.

(v) During the confinement, the utilization review organization will monitor the participant's medical chart for appropriateness of treatment. Toward the end of the assigned length of stay, the utilization review organization will contact hospital personnel to ensure discharge is scheduled to occur as planned. If the attending physician believes additional days of confinement are necessary, he may request an extension on the number of days, and will be required to submit medical data to substantiate the request.

(b) Open Access III Plan

(i) Outpatient surgeries, "certain" ancillary services and diagnostic testing will require pre-certification.

(ii) Elective hospital admissions, except those for obstetrical care, must be approved by the utilization review organization in advance. Elective admissions are defined as admissions that do not involve emergency care.

(iii) Elective hospital admissions will not be approved for any Saturday, Sunday, or nationally recognized legal holiday that occurs on Friday or Monday unless, on the day of admission, the participant receives medically necessary services that can only be rendered in a hospital and cannot be postponed.

(iv) Further, admission will not be approved for the day before a surgical procedure is scheduled to be performed unless, on the day of admission, the participant receives medically necessary services that can only be rendered in a hospital.

(v) When an admission is approved, the utilization review organization will determine a length of stay appropriate to the nature and severity of the participant's condition.

(vi) During the confinement, the utilization review organization will monitor the participant's medical chart for appropriateness of treatment. Toward the end of the assigned length of stay, the utilization review organization will contact hospital personnel to ensure discharge is scheduled to occur as planned. If the attending physician believes additional days of confinement are necessary, he may request an extension on the number of days, and will be required to submit medical data to substantiate the request.

9.03 Admission Review

Hospital admissions for obstetrical care and/or emergency care require admission review. In all cases, the utilization review organization must be notified of the admission within 48 hours or on the next working day, if later. The utilization review organization will assign an appropriate length of stay and will monitor the participant's care as outlined above.

ARTICLE X

COORDINATION OF BENEFITS

10.01 Applicability

(a) The Coordination of Benefits ("COB") provision applies to the Plan when a participant has health care coverage under more than one health plan. Health plan, for purposes of this Article, is defined in Section 10.02 (a).

(b) If this COB provision applies, Section 10.03 should be examined. Those rules determine whether the benefits of the Plan are determined before or after those of another health plan. The benefits of the Plan:

(i) shall not be reduced when, under Section 10.03, the Plan determines its benefits before another health plan; but

(ii) may be reduced when, under Section 10.03, another health plan determines its benefits first. This reduction is described in Section 10.04.

(c) Other insurance coverage on dependents will be verified annually by the plan administrator.

10.02 Definitions

(a) Health plan means any of these that provide benefits or services for, or because of, medical or dental care or treatment:

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. This provision does not include individual contracts, hospital indemnity-type coverages that are written on a non-expense incurred basis, student accident coverages, or automobile medical insurance plans.

(ii) Coverage under a governmental plan required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits exceed those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under Section 10.02 (a) (i) or (ii) is a separate health plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate health plan.

(b) Primary Plan/Secondary Plan

Section 10.03 states whether the Plan is a primary plan or secondary plan as to another health plan covering the person.

When the Plan is a primary plan, its benefits are determined before those of the other health plan and without considering the other health plan's benefits.

When the Plan is a secondary plan, its benefits are determined after those of the other health plan and may be reduced because of the other health plan's benefits.

When there are more than two health plans covering the person, the Plan may be a primary plan as to one or more other health plans, and may be a secondary plan as to a different health plan.

(c) Allowable Expense means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the health plan.

When a health plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

(d) Claim Determination Period means a calendar year. However, it does not include any part of a year during which a person has no coverage under the Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

10.03 Order of Benefit Determination Rules

(a) General - When there is a basis for a claim under the Plan and another health plan, the secondary plan is one whose benefits are determined after those of the other health plan, unless:

(i) the other health plan has rules coordinating its benefits with those of the Plan; and

(ii) both those rules and the Plan's rules, in the subparagraph below, require that the Plan's benefits be determined before those of the other health plan.

(b) Rules - The Plan determines its order of benefits using the first of the following rules that applies:

(i) Subscriber - The benefits of the health plan that covers the person as a subscriber (that is, other than as a dependent) are determined before those of the health plan that covers the person as a dependent.

(ii) Dependent Child/Parents not Separated or Divorced - Except as stated in the subparagraph below, when the Plan and another health plan cover the same child as a dependent of different persons, called parents:

(A) the benefits of the health plan of the parent whose birthday falls earlier in a year are determined before those of the health plan of the parent whose birthday falls later in that year; but

(B) if both parents have the same birthday, the benefits of the health plan that covered the parent longer are determined before those of the health plan that covered the other parent for a shorter period of time.

(iii) Dependent Child/Separated or Divorced Parents - If two or more health plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(A) first, the health plan of the parent with custody of the child;

(B) then, the health plan of the spouse of the parent with custody of the child; and

(C) finally, the health plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the health plan of that parent has actual knowledge of those terms, the benefits of that health plan are determined first. This paragraph does not apply with respect to any claim determination period or calendar year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(iv) Active/Inactive Employee - The benefits of a health plan that covers a person as an employee who is neither laid off, terminated, on long-term disability, nor retired (or as that employee's dependent) are determined before those of a health plan that covers that person as a laid-off, terminated, disabled, or retired employee (or as that employee's dependent). If the other health plan does not have this rule, and if, as a result, the health plans do not agree on the order of benefits, this rule (iv) is ignored.

(v) Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the health plan that covered a subscriber longer are determined before those of the health plan that covered that person for the shorter time.

10.04 Effect on the Benefits of the Plan

This section applies when, in accordance with Section 10.03, the Plan is a secondary plan as to one or more other health plans. In that event the benefits of the Plan may be reduced under this section. Such other health plans are referred to as "the other health plans" in (a) immediately below.

(a) Reduction in the Plan's Benefits -The benefits of the Plan will be reduced when the sum of:

(i) the benefits that would be payable for the allowable expenses under the Plan in the absence of this COB provision; and

(ii) the benefits that would be payable for the allowable expenses under the other health plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the Plan will be reduced so that they and the benefits payable under the other health plans do not total more than those allowable expenses. When the benefits of the Plan are reduced as described above, each benefit is reduced

in proportion. It is then charged against any applicable benefit limit of the Plan.

10.05 Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The claims administrator has the right to decide which facts are needed, and may get needed facts from or give them to any other organization or person. The claims administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Plan must give the claims administrator any facts needed to pay the claim.

10.06 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under the Plan. If that occurs, the claims administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under the Plan. The claims administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

10.07 Right of Recovery

If the amount of the payments made by the claims administrator is more than should have been paid under this COB provision, recovery of the excess may be made from one or more of:

(a) the persons paid or for whom paid;

(b) insurance companies; or

(c) other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ARTICLE XI

CONTINUATION OF COVERAGE

11.01 General Information

This Article assures compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and applicable regulations and amendments.

Any qualified beneficiary who would lose coverage under the Plan as a result of a qualifying event is entitled to elect, within the COBRA election period, to continue coverage under the Plan pursuant to this Article. Individuals eligible for Medicare, excluding former spouses, will not be entitled to elect.

11.02 Qualified Beneficiary

For purposes of this Article, the term "qualified beneficiary" means, with respect to a subscriber, any other individual who, on the day before the qualifying event for that subscriber, is a participant under the Plan as:

(a) the spouse of the subscriber; or

(b) the dependent child of the subscriber.

In the case of a qualifying event specified in Section 11.03(b), the term "qualified beneficiary" will include the subscriber.

11.03 Qualifying Event

For purposes of this Article, the term "qualifying event" means, with respect to a subscriber, any of the following events that, but for the continuation of coverage provided for in this Article, would result in the loss of coverage of a qualified beneficiary:

(a) the death of the subscriber;

(b) the termination (other than by reason of such employee's gross misconduct), or reduction in hours, of the employee subscriber's employment;

(c) the subscriber's divorce or legal separation from his covered spouse;

(d) the subscriber's entitlement to Medicare, if such entitlement would result in loss of coverage; or

(e) a dependent child's ceasing to be a dependent child, as defined under the plan.

11.04 Applicable Premium

For purposes of this Article, the term "applicable premium" means the cost of the coverage as determined pursuant to the code.

11.05 COBRA Election Period

For purposes of this Article, the term "COBRA election period" means the 60-day period beginning on the later of the date on which coverage terminates under the Plan by reason of a qualifying event or the date notice is given to a participant pursuant to Section 11.10.

11.06 Maximum Coverage Period

In the case of a qualifying event specified in Section 11.03(b), coverage may be continued, pursuant to this Article:

(a) for a maximum period of l8 months following the qualifying event;

(b) if the qualified beneficiary is determined, under Title II or Title XVI of the Social Security Act, to have been disabled at the time of a qualifying event specified in Section 11.03(b), coverage may be extended from 18 to 29 months;

(c) if a second qualifying event occurs during the 18 or 29 month period immediately following the date of the qualifying event specified in Section 11.03(b), and while continuation coverage is in effect, coverage may be continued pursuant to this Article for a maximum period of 36 months after the date of the initial qualifying event, but only for those individuals who are qualified beneficiaries in their own right; or

(d) if the event described in Section 11.03(d) occurs (without regard to whether such event is a qualifying event) during the 18 or 29 month period immediately following the date of the qualifying event specified in Section 11.03(b), and while coverage is in effect, coverage for qualified beneficiaries, other than the covered employee for such event or any subsequent qualifying event, may be continued pursuant to this Article for a maximum period of 36 months after the date of the initial qualifying event.

11.07 Terminating Events

The 18-, 29- and 36-month periods specified in Section 11.06 are the maximum continuation periods required by law. However, in no event may coverage be continued beyond:

(a) the first day, after the qualified beneficiary elects to continue coverage, on which the qualified beneficiary is covered under another employer's medical plan provided the new plan does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary;

(b) the day the qualified beneficiary is entitled to Medicare coverage, except for former spouses who are Medicare eligible and those qualifying under Section 11.03(d);

(c) the end of the last period for which timely premium payments are made pursuant to Section 11.09; or

(d) termination of the Plan.

11.08 Rights and Privileges during Continuation Period

During the continuation period, each qualified beneficiary will be afforded the same rights and privileges, with respect to bringing in new dependents and choosing HMO participation as regular subscribers; however, the only dependents who will be considered qualified beneficiaries in their

own right are those who were enrolled in the Plan on the day immediately preceding the initial qualifying event.

11.09 Premium Requirements

The applicable premium for any continuation of coverage pursuant to this Article will be paid by the qualified beneficiary in a timely manner and in monthly installments. Continuation of coverage will cease pursuant to this Article upon the failure to make timely payment of any applicable premium with respect to the participant for whom coverage has been continued. The initial payment will be deemed timely if received within 45 days of the date the election is made; subsequent payments will be due on the first day of the month for which they apply, with a grace period of 30 days following such due date.

11.10 Notice Requirements

(a) The Board of Trustees will provide, at the time of commencement of coverage, written notice to each employee subscriber and to the spouse (if any) of the subscriber, of the rights provided under this Article.

(b) The Board of Trustees will provide, at the time of a qualifying event specified in Sections 11.03(a), (b), and (d), written notice to each employee subscriber and to the spouse (if any) of the subscriber, of the rights provided under this Article.

(c) The subscriber or the qualified beneficiary is responsible for notifying the Board of Trustees of a divorce or legal separation, or cessation of dependent eligibility within 60 days after the date of such qualifying event. The qualified beneficiary who is determined under Title II or Title XVI of the Social Security Act, to have been disabled at the time of a qualifying event specified in Section 11.03(b) is responsible for notifying the Board of Trustees of such determination within 60 days after the date of the determination and for notifying the Board of Trustees within 30 days of the date of any final determination under such titles that the qualified beneficiary is no longer disabled.

(d) The Board of Trustees will notify any qualified beneficiary of such qualified beneficiary's rights under this Article within 14 days of receiving the notice pursuant to Section 11.10(a) or within 14 days of the qualifying event, whichever is applicable. Any notification to an individual who is a qualified beneficiary as the spouse of the subscriber will be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

ARTICLE XII

CLAIM PROCEDURE AND ARBITRATION RIGHTS

12.01 Claim for Benefits

Initial Determination - Any claim for benefits will be made to the claims administrator. If the claims administrator denies a claim, the claims administrator will provide notice to the subscriber, in writing, within 60 days after the claim is filed. The notice will set forth the reasons for the denial or adjustment.

12.02 Payment of Benefits

(a) When services are received from a participating network provider, the provider will file all necessary claims and the claims administrator will make payment directly to the provider. The claims administrator is authorized to make payments directly to providers furnishing covered services for which benefits are provided under the Plan, provided the charges are submitted on an approved claim form along with an assignment of payment to the provider. The claims administrator reserves the right in all instances to make payments directly to the subscriber. Any payments made by the claims administrator will discharge the Plan's obligation with respect to the amounts so paid.

All claims must be submitted within 12 months after covered services are rendered to be eligible for payment.

(b) The claim must include the data necessary for the claims administrator to determine benefits. Itemized bills must be filed with the claim form and such bills will not be returned. Benefits will be paid directly to the subscriber or provider.

(c) The rights of a participant and the benefits to which he is entitled or for which he applies under the Plan are not assignable, except for assignment of payments to a provider, or in accordance with the subrogation provisions of the Plan.

(d) After covered services are rendered, the claims administrator will have no liability to any person because of the refusal of a request to pay or withhold payment for such services.

(e) All benefits owed to the participant at death will be paid to the participant's estate. If there is no estate, the Plan reserves the right to make payment to a relative by blood or by marriage who appears to be equitably entitled to payment. The participant and his estate will hold the Plan harmless for any improper payments. This provision will be binding on all successors, administrators and assigns acting on behalf of the participants.

(f) The Board of Trustees, at its own expense, will have the right and opportunity to have a physician of its choice examine the participant who is requesting payment, when and as often as it may reasonably require, during the pendency of a request. The Board will also have the right to have an autopsy performed in case of death, where it is not forbidden by law.

12.03 Arbitration Rights

(a) The Missouri Department of Transportation and Missouri State Highway Patrol shall maintain the Arbitration Committee for the purpose of resolving disputed claims. The membership of the committee shall be appointed by the respective chief administrative officers.

The committee may be contacted as follows:

MoDOT and MSHP Arbitration Committee
Medical and Life Insurance Plan
P. O. Box 270
Jefferson City, MO 65102

(b) If any participant covered under the Plan, as evidenced by coverage being in force at the time of loss, shall disagree with the adjustment of any claim, the participant shall make written request to the claims administrator for reconsideration and furnish any additional information to substantiate the claim. The claims administrator will review any new information submitted, reconsider the claim and then supply a written response to the participant to support either a second denial or allow payment of the claim. If benefits are again denied by the claims administrator, the participant may submit a letter of disagreement (along with a copy of the claims administrator's second denial report and supporting information) to the Arbitration Committee. The Arbitration Committee shall meet as soon as possible to evaluate the disputed claim.

(c) Arbitration Committee decisions will be forwarded to the Board of Trustees for final consideration.

(d) The Board of Trustees may request further evaluation of a disputed claim by submitting the claim to a professional medical group, which provides retrospective reviews of medical services to plan participants. If a review is to be performed, all documentation will be submitted to the professional medical group for their consideration and recommendation.

(e) The Arbitration Committee will notify the participant in writing of all final decisions with a copy to the Board of Trustees and the claims administrator.

12.04 Legal Action

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of 60 days after a claim has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three years from expiration of time within which proof of loss is required by the plan.

12.05 Misstatements

(a) Misstatements made at the time of enrollment or when a claim is made may be grounds for denying enrollment, canceling enrollment or refusing claim payment.

(b) Any misstatements involving Articles I – XVII of the Plan may be used in canceling enrollment or denying enrollment in the State Paid Life Insurance Plan and/or Optional Life Insurance Plan.

(c) Failure to cooperate with the Board of Trustees (or their designated representatives), the claims administrator or the Arbitration Committee with regard to the investigation of a claim may result in denial of that claim and subsequent claims.

ARTICLE XIII

FUNDING POLICY

13.01 General Information

The State, through a Board of Trustees, will control the funds, establish the premium rates, implement necessary or desired policy revisions and provide general administrative control.

Amounts needed to pay claims and expenses, and to fund the Plan's reserve liabilities, are determined periodically by an independent actuary subject to approval by the Board of Trustees and the Commission.

13.02 State Contributions

(a) Employee Subscriber -

(i) The state will contribute a certain amount per month for each employee, long-term and work-related disability recipient. The state's contribution for the employee will be that portion of their contribution that is not used for the state life insurance premium.

(ii) No state contribution will be made for employee subscribers who are on leave of absence without pay. Such subscribers may continue coverage by paying the required contribution without state participation.

(iii) Active employees on active military leave who continue their medical coverage will receive the state share as long as they are on a paid leave status.

(iv) Family medical leave recipients in paid or unpaid leave status will receive the state contribution for 12 weeks per calendar year.

(b) Non-Subscriber Employees - If an employee refuses or is not yet eligible for Plan coverage, the state contribution will be added to the funds established to finance the medical and life insurance plans. In no event will a non-subscriber employee receive reimbursement of the state contribution.

(c) Retiree Subscriber - The state will contribute a certain amount per month for each retiree subscriber, provided the retiree has been retained as a special consultant as authorized in Chapter 104 RSMo.

(d) Surviving Spouse Subscriber - The state will contribute a certain amount per month for each surviving spouse subscriber.

(e) Vested and Continuation of Coverage (C.O.B.R.A.) Subscribers - These subscribers will receive no state contribution.

13.03 Subscriber Contribution Amount

The subscriber contribution will vary depending upon the type of subscriber coverage selected, the amount needed to fund the Plan, and the amount of state contribution authorized by the legislature.

13.04 Payment of Subscriber Contributions

Subscriber contributions are due in advance of the coverage date.

All contributions will be collected by payroll deduction unless:

(a) the subscriber is not eligible to receive a payroll or retirement check or one sufficient to cover the required contribution, or

(b) the employee is on an authorized leave of absence without pay.

If payroll deduction payments are not available, the subscriber will be required to make payments in a manner prescribed by the Board of Trustees.

13.05 Grace Period on Subscriber Contributions

Subscriber contributions are due prior to the first day of each month of coverage, with a grace period of 30 days. If payment is not received prior to the end of such grace period, coverage will end as of the first day of the month for which the subscriber was delinquent.

13.06 Reimbursement of Contributions

A participant may apply to the Board of Trustees for reimbursement of excess contribution as follows:

(a) request for reimbursement must be made prior to the beginning of a new month of coverage;

(b) reimbursement shall be limited to two months' excess contribution unless the excess contribution was made in reliance on misstatements of the Board of Trustees or its designated representatives, in which case reimbursement shall be limited to 12 months' excess contribution;

(c) if a participant should have been enrolled in Medicare Parts A and B but failed to advise the Board of Trustees or its designated representative, reimbursement shall be limited to two months' excess contribution; or

(d) there shall be no limitation on refunds of excess contributions made due to death or retroactive eligibility for Medicare coverage.

Partial month reimbursement will not be allowed. Any claims by the participant paid in the refund period will be recovered by the Plan.

ARTICLE XIV

REIMBURSEMENT

14.01 Reimbursement for Third Party Liability

Pursuant to Section 104.270, RSMo, and effective January 1, 2003, the commission requires the participant/subscriber to reimburse the Plan for any medical claims paid by the Plan for which there was third-party liability.

The participant/subscriber shall provide information requested by either the Board of Trustees or the third-party administrator regarding the existence of third-party liability. Failure to provide such information may result in the suspension of benefits under the Plan for any and all services including services which are unrelated to the information requested.

Reimbursement to the Plan will be required whenever the participant/subscriber receives payments for physical or mental treatment from individuals, insurance companies, settlements or court verdicts. Any reimbursement shall not exceed the amount actually paid by the Plan.

Reimbursement to the Plan will not be required if the person injured is the policyholder of other liability coverage; however, if the person injured is a dependent of the policyholder of other liability coverage, the Plan can require reimbursement. It is the responsibility of the participant/subscriber to provide to the satisfaction of the Board of Trustees evidence of such insurance.

Failure of any participant/subscriber to provide reimbursement could at the discretion of the Board of Trustees result in the nonpayment of services covered by the Plan including services which are not related to the reimbursement.

ARTICLE XV

ADMINISTRATION

15.01 Plan Administration

The operation of the Plan will be under the supervision of the Board of Trustees. It shall be a principal duty of the Board to ensure that the Plan is carried out in accordance with its terms, and for the exclusive benefit of employees and others entitled to participate in the Plan. The Board of Trustees will have full authority to administer the Plan in all of its details; subject, however, to directives of the Commission and pertinent provisions of the code and other applicable law. The Board's authority includes, but is not limited to, the following:

(a) to enforce such rules and regulations as the Board deems necessary or proper for the efficient administration of the Plan;

(b) to interpret the Plan, with the Board's interpretations thereof in good faith to be final and conclusive on all persons claiming or administering benefits under the Plan;

(c) to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;

(d) to approve reimbursement requests and to authorize the payment of benefits; and

(e) to select claims administrators, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan.

15.02 Examination of Records

The Board will make available to each participant records pertaining to the participant for examination at reasonable times during normal business hours.

ARTICLE XVI

AMENDMENT OR TERMINATION OF PLAN

16.01 Amendment

The employer, at any time may amend any or all of the provisions of the Plan without the consent of any employee or participant. However, such amendment will be without prejudice to any valid claim with respect to covered services rendered prior to the effective date of the amendment.

16.02 Termination

The employer reserves the right to terminate the Plan, in whole or in part, at any time. However, such termination will be without prejudice to any valid claim with respect to covered services rendered prior to the effective date of termination.

ARTICLE XVII

MISCELLANEOUS

17.01 Health Maintenance Organizations (HMO)

(a) General Information - The Board of Trustees may contract with federally qualified and/or state licensed HMO's, which serve areas in which employees reside.

(b) Annual Open Enrollment - An open enrollment period will be held each year, during the month of October, in areas served by qualified HMO's that have contracts with the Board of Trustees. During this open enrollment period participants will be allowed to change their enrollment from the Plan to a HMO or from a HMO to the Plan if certain conditions are met. Any such change in enrollment will be effective on the first day of January and will continue in effect for twelve months unless the participant ceases to be eligible to participate in the Plan.

Spouses and stepchildren enrolled due to marriage, and newborn, unmarried, legally adopted children added during the time the subscriber was enrolled in the HMO may be added to the Plan during the open enrollment period.

A change of health plan option at any time other than an open period will require a qualifying event as stated in Section 1.48.

(c) Dual Choice Option to be Offered to New Employees - While the Board of Trustees is under contract to a HMO, all new employees who reside in that HMO's service area will be allowed to choose between the Plan and the appropriate HMO. Enrollment in a HMO is at the option of the participant.

(d) Contributions to Health Maintenance Organizations (HMO) - The Board of Trustees will arrange for the payment of the required state and participant contributions to the HMO, but in no event will the state contribution toward any HMO exceed the state contribution for a similarly situated participant under the Plan.

17.02 Plan Interpretation

The Plan document sets forth the provisions of the Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan. The Plan shall be read in its entirety and not severed except as provided below.

17.03 Conversion Privilege

There are no conversion privileges under the Plan.

17.04 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

17.05 Limitation on Employee Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

(a) to give any person any legal or equitable right against the employer, the Board of Trustees, or the claims administrator, except as expressly provided herein or provided by law;

(b) to create a contract of employment with any employee, to obligate the employer to continue the service of any employee or to affect or modify the terms of employment of any person in any way; or

(c) to create any vested rights to benefits or the right to benefits after the termination of coverage.

17.06 Governing Law

To the extent not preempted by federal law, the provisions of the Plan shall be construed, enforced and administered according to the laws of the state of Missouri.

17.07 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

17.08 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way will affect the Plan or the construction of any provision thereof.

17.09 Non-Gender Clause

Whenever used in the Plan, the masculine gender will include the feminine and the plural form will include the singular.

17.10 Communication

Communication between the Plan and a participant will be addressed to the subscriber. As used in this section, the term communication includes provider directories, checks, explanation of benefits and general correspondence.

MISSOURI DEPARTMENT OF TRANSPORTATION
AND
MISSOURI STATE HIGHWAY PATROL

STATE PAID LIFE INSURANCE PLAN

I. ELIGIBLE EMPLOYEES

All employees and individuals on long-term disability status with the Missouri Department of Transportation and Missouri State Highway Patrol who are members of the Missouri Department of Transportation Employees' and Highway Patrol Retirement System.

II. EFFECTIVE DATE OF COVERAGE

Any employee who accepts the life insurance coverage shall become a participant as follows:

A. If the employee begins work on the first working day of the month, coverage shall be effective on that date.

B. If the employee begins work after the first working day of the month, coverage shall be effective on the first day of the following month.

Application must be made within 31 days after eligibility.

III. AMOUNT OF LIFE INSURANCE

A. Beginning January 1, 2001, the maximum amount of insurance for which an active employee is eligible shall be one (1) times the annual salary rounded to the next higher $1,000. The Missouri Department of Transportation and the Missouri State Highway Patrol provide this benefit at no cost to the employee. This amount will be established in July of each year based upon the employee's salary at that time and will be effective the following January first.

B. Long-term disability members approved for benefits prior to January 1, 2002, will continue with the amount they currently have in force. A long-term disability member approved for disability benefits after January 1, 2002, can retain the amount of insurance coverage in force on the date he ceased to be an active full-time, permanent part-time or seasonal employee eligible for benefits.

C. This coverage shall provide for triple indemnity if death is a result of injury or disease occurring on or after the effective date of insurance and arising out of and in the course of actual performance of duty as an employee.

IV. COST

There shall be no cost to the employee for the life insurance provided, unless such employee is on an authorized leave of absence without pay for the purpose of military, education, maternity, illness, emergency, family medical leave, etc. In such cases, the employee may continue coverage by paying the required premium normally paid by the state for the amount of coverage provided.

Evidence of insurability will not be required if an employee's insurance was canceled while on an authorized leave of absence and he later returns to work. The employee will qualify for coverage as soon as he is paid on the payroll. An A-560 form should be completed at that time for re-enrollment.

Individuals on long-term disability status who desire to continue the life insurance coverage, must pay the required premium normally paid by the state for the amount of coverage provided. The premium payment is to be made through payroll deduction.

V. BENEFICIARY

The beneficiary(s) must be named by the employee/long-term disability recipient on the furnished form. The beneficiary(s) may be changed by completing and filing the required form.

VI. TERMINATION OF COVERAGE

Coverage for terminating or retiring employees terminates at the end of the month in which the employee terminates or retires.

Coverage for individuals on long-term disability status will terminate in the event the individual retires or decides to cancel the payroll deduction for the required premium payment. If coverage is canceled while on long-term disability, re-enrollment is not allowed until employee returns to active work status.

VII. CONVERSION PRIVILEGE

If insurance, or any portion thereof, terminates, then any individual covered under the Policy may convert his life insurance to a conversion policy without providing Evidence of Good Health.

To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to the insurance carrier and pay the premium required for his age and class of risk.

MISSOURI DEPARTMENT OF TRANSPORTATION
AND
MISSOURI STATE HIGHWAY PATROL

OPTIONAL GROUP LIFE INSURANCE PLAN

I. ELIGIBILITY PROVISIONS

A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

All employees and individuals on long-term disability status with the department or the patrol who are members of the Missouri Department of Transportation Employees' and Highway Patrol Retirement System and who are currently covered under the State Paid Life Insurance Plan are eligible. Employees who retired on or before May 1, 1982 are not eligible for the Optional Group Life Insurance .

Any employee who retires or is approved for work-related disability may retain insurance coverage as specified in III, "Amount of Life Insurance".

No retiree or disability recipient may terminate coverage and later re-enroll.

Employees on a documented military leave of absence may elect to continue their coverage as long as premiums are paid and they have continued their State Paid Life coverage.

B. Dependents - Spouse and/or Child(ren)

Any employee or long-term disability recipient enrolled in optional life coverage may apply for dependents optional life coverage for spouse and/or child(ren).

(1) Spouse means the person to whom you are legally married.

(2) Child means your unmarried child from live birth, unmarried adopted child, and unmarried stepchild and/or dependent grandchild living with you, all covered up to 23 years of age.

Coverage will be cancelled on dependents called up for active duty in full-time military, naval or air force service. Coverage can be re-instated for the amount in force prior to military service, upon separation from the military and re-enrollment (must still qualify as a dependent).

II. EFFECTIVE DATE OF COVERAGE

A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

The effective date of coverage of a new employee will be on the first day of the calendar month following date of employment. For insurance coverage to become effective, the employee must enroll for coverage, authorize payroll deduction to pay the cost of the coverage and meet the active work provisions of the current policy.

Employees who do not meet the active work provisions on the effective date will be eligible for coverage when they return to their assigned duties as specified in the policy.

All employees shall become insured on the effective date of their retirement or disability in accordance with III, "Amount of Life Insurance", if they make written application for coverage and authorize a retirement payroll deduction to pay for their insurance coverage at the same time they apply for retirement benefits.

B. Dependents - Spouse and/or Child(ren)

Dependent coverage may become effective on the first day of the next calendar month following the employee's date of hire. For insurance coverage to become effective the employee must:

(1) be enrolled in Optional Group Life Insurance on that date;

(2) enroll for dependent coverage;

(3) authorize payroll deduction to pay the cost of the coverage; and

(4) meet the active work provisions of the current policy.

Coverage on dependents of employees, who do not meet the active work provisions will become effective on the date the employee returns to their assigned duties as specified in current policy.

III. AMOUNT OF LIFE INSURANCE

A. Employees

The maximum amount of insurance for which an employee is eligible shall be six times the annual salary rounded to the next higher $1,000 and not to exceed $800,000.

Long-term disability members approved for benefits prior to January 1, 2002, will continue with the amount they currently have in force. A long-term disability member approved for disability benefits after January 1, 2002, can retain the amount of insurance coverage in force on the date he ceased to be an active full-time, permanent part-time or seasonal employee eligible for benefits.

The amount of coverage for employees and long-term disability recipients can be less than the maximum amount but all coverage must be in multiples of $1,000.

B. Retirees (Retirement date prior to 9-1-98.)

(1) Employees retiring before May 1, 1984 may retain an amount no greater than $2,500 in multiples of $500.

(2) Employees retiring on or after May 1, 1984, may retain an amount no greater than $5,000 in multiples of $500.

(3) Employees retiring on or after September 1, 1988 may retain an amount no greater than $10,000 in multiples of $500.

(4) Employees retiring on or after May 1, 1996 may retain an amount no greater than $60,000 in multiples of $500.

C. Retirees under the "Closed Plan" (Retirement date 9-1-98 or thereafter), retirees under the "Year 2000 Plan" (Retirement date 7-1-2000 or thereafter) who do not receive the temporary annuity of .8%, and work-related disability recipients may retain Optional Group Life Insurance as follows:

(1) Employees who carry Optional Group Life Insurance in an amount of $60,000 or greater may retain coverage not to exceed $60,000.

(2) Employees who carry Optional Group Life Insurance in an amount less than $60,000 may retain the amount of optional coverage they had as an employee, plus the amount of their State Paid Life Insurance, not to exceed $60,000. Any employee with less than $60,000 (Optional plus State Paid) as an active employee must provide evidence of insurability to increase their amount (maximum $60,000). Application for increased coverage must be made prior to retirement.

Example: An employee carries $15,000 Optional Group Life Insurance, plus $30,000 State Paid Life Insurance, for a total of $45,000 in coverage. The maximum amount of Optional Group Life Insurance this employee may carry into retirement or work-related disability (without evidence of insurability) is $45,000.

(3) Employees who carry only the State Paid Life Insurance may elect Optional Group Life Insurance in an amount equal to their State Paid Life, not to exceed $60,000, without evidence of insurability. If State Paid Life coverage is less than $60,000, they must provide evidence of insurability to increase their coverage (maximum $60,000). Application for increased coverage must be made prior to retirement.

(4) Employees who did not carry the State Paid Life Insurance at the time of their retirement or work-related disability **are ineligible** to enroll in Optional Group Life Insurance.

D. Retirees (Retirement date 7-1-2000 or thereafter) retiring under the "Year 2000 Plan" and receiving the temporary annuity of .8% may retain Optional Group Life Insurance as follows:

(1) Employees who carry Optional Group Life insurance can retain the amount of optional coverage in effect the month prior to retirement (State Paid coverage cannot be included in this amount).

(2) Retirees receiving the temporary annuity, with optional coverage in excess of $60,000, must reduce their coverage to a maximum of $60,000 at age 62.

E. Spouse

Spouse insurance may be purchased in multiples of $1,000, up to a maximum of $100,000. The amount of spouse insurance may not exceed the amount of insurance carried by the employee/long-term disability recipient.

F. Child(ren)

Child(ren) insurance is issued for a fixed amount of $10,000 of coverage per child.

IV. ADJUSTMENTS IN THE AMOUNT OF COVERAGE OR PREMIUM

A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

If an employee, long-term or work-related disability recipient, or retiree's birthday causes him to be placed into an age bracket requiring a higher premium, the payroll deduction premium will be automatically increased the month of birth to be effective the first day of the following month.

If the basic annual wage/benefit of an employee decreases and reduces the maximum amount of coverage the employee is entitled to, such reduction will automatically take effect on the first day of the month following the reduction in eligibility.

Retirees and work-related disability recipients may reduce the amount of their coverage in $500 increments at any time but may not increase the amount of their coverage.

Long-term disability recipients may reduce the amount of their coverage in $1,000 increments at any time but may not increase the amount of their coverage. Long-term disability recipients cannot discontinue coverage and later re-enroll; however, if they have maintained the State Paid Life Insurance they may enroll in the Optional Group Life Insurance upon retirement for the same amount as their State Paid Life Insurance, not to exceed $60,000. If a long-term disability recipient had canceled his Optional Group Life Insurance and returns to active work status he can re-enroll with approved evidence of insurability.

Employees participating in the Optional Group Life Insurance will be given the option to increase their coverage without evidence of insurability on January 1, each year, to reflect increases in their basic annual wages, based on their July 1 salary of the preceding year. This increase is not automatic and must be initiated by the employee.

B. Spouse

If the birth date of the employee or long-term disability recipient causes the spouse to be placed into an age bracket requiring a higher premium, the payroll deduction premium will be automatically increased in the employee's month of birth to be effective on the first day of the following month.

If the basic annual wage of an employee decreases and reduces the amount of Optional Group Life Insurance for that employee, the amount of spouse insurance may be reduced. If the amount of spouse insurance reduces, the reduction will automatically take effect on the first day of the month following the reductions in wage or benefit.

If the basic annual wage of an employee increases, the amount of spouse insurance may be allowed to increase, subject to the limitations of the Plan with evidence of insurability. This increase must be initiated by the employee.

V. COST

The cost of the insurance is based upon the amount of coverage times the rate for their appropriate age bracket.

The cost of insurance for a spouse is based upon the amount of coverage times the rate for the employee's or long-term disability recipient's appropriate age bracket.

Rates are based on a contract bid by an insurance carrier and may change. Participants will be notified in advance of any such changes.

VI. BENEFICIARY

A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

The employee, long-term or work-related disability recipient or retiree must designate a beneficiary or beneficiaries before insurance becomes effective. Such a designation must be indicated on the furnished form. The beneficiary or beneficiaries may be changed by completing and filing the required form.

B. Dependents - Spouse and/or Child(ren)

The employee or long-term disability recipient is the beneficiary of dependents Optional Group Life Insurance.

VII. EVIDENCE OF INSURABILITY

A. General Requirements

If evidence of insurability is required based on one of the conditions listed below, you must complete and submit a Medical History Statement along with the enrollment form to your insurance representative. Any proposed insured may also be asked to have a health examination. If the insurance company approves coverage, the insurance will become effective on the first day of the month following the date of approval if the employee meets the active work provisions of the current policy.

B. Employees

Evidence of insurability will be required if enrollment is not made within 31 days from the date of employment.

Employees who wish to increase their coverage for any reason other than a wage increase will be required to show evidence of insurability.

Employees on a documented military leave of absence who cancel their coverage or coverage is terminated due to nonpayment of premiums must complete a medical history statement for themselves and their dependents and be approved before coverage can be reinstated.

Employees and long-term disability recipients planning to retire and wishing to retain insurance after retirement will not be required to show evidence of insurability except as set forth in Section III. C., (2), (3).

C. Dependent – Spouse

Evidence of insurability will be required if enrollment for spouse Optional Group Life Insurance is not made within 31 days of the date of eligibility.

Evidence of insurability will be required at any time when the desired amount of spouse insurance exceeds $10,000.

Evidence of insurability will be required at any time after the initial eligibility period if you request an increase in the amount of spouse insurance.

D. Dependent – Children

Evidence of Insurability will not be required for child(ren) coverage at any time.

VIII. TERMINATION OF COVERAGE

A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

The participant's Optional Group Life Insurance terminates as follows:

(1) termination of this policy;

(2) terminating employees at the end of the last month of employment;

(3) retiring employees at the end of the last month of employment unless the employee enrolls under the retiree provisions;

(4) transfers from the long-term or work-related disability status to retiree status, unless the disability member enrolls under the retiree provisions; or

(5) failure to make required premium payment.

Optional coverage can be terminated at any time by the member.

B. Dependents - Spouse and/or Child(ren)

Coverage for dependents will terminate as follows:

(1) child's marriage;

(2) child attains age 23 years; or

(3) 23rd birthdate of handicapped child, unless employee reapplies for coverage within 31 days of the normal termination date and child is approved for handicapped status.

The spouse and/or child(ren) coverage will terminate if employee or long term disability recipient terminate their coverage.

Spouse coverage terminates in the event of divorce.

The spouse and/or child(ren) coverage may be terminated by the employee at any time.

IX. CONVERSION PRIVILEGE

If insurance or any portion thereof, terminates, then any individual covered under the Policy may convert his life insurance to a conversion policy without providing Evidence of Good Health.

To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to the insurance carrier and pay the premium required for his age and class of risk.